PRINTED: 7/12/2023 FORM APPROVED 2567-L

NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHABILITATION CENTER STATE LICENSE NUMBER: 970202 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY ID PROVIDER'S PLAN OF CORRECTION (EACH (X5)		OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
SOMERSET HEALTHCARE & REHABILITATION CENTER SOMERSET, PA 15501 STATE LICENSE NUMBER: 970202 (X9.10) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY INC.) PREFIX TAG DENTIFYING INFORMATION) FOR 0000 INITIAL COMMENT Based on a Medicare/Medicaid Recertification survey, State Licensure survey, Civil Rights Compliance survey, and a complaint survey completed on May 18, 2023, it was determined that Somerset Healthcare and Rehabilitation Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations. F 0625		395398			B. WING: _		05/18/2023	
SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATIONY OR LSC DENTIFY INFORMATION) PREFIX TAG	SOMERSE	228 SIEMON	DRIVE	IP CODE:				
PREFIX TAG MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 0000 INITIAL COMMENT Based on a Medicare/Medicaid Recertification survey, State Licensure survey, Civil Rights Compliance survey, and a complaint survey completed on May 18, 2023, it was determined that Somerset Healthcare and Rehabilitation Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations. F 0625	STATE LICENS	E NUMBER: 970202						
Based on a Medicare/Medicaid Recertification survey, State Licensure survey, Civil Rights Compliance survey, and a complaint survey completed on May 18, 2023, it was determined that Somerset Healthcare and Rehabilitation Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations. F 0625	PREFIX	MUST BE PRECEEDE	ED BY FULL REGULATORY O			CORRECTIVE ACTION SHO	OULD BE	COMPLETE
	F 0000	Based on a Medicare/N survey, State Licensure Compliance survey, an completed on May 18, Somerset Healthcare an not in compliance with 42 CFR Part 483, Subp Long Term Care Facili Commonwealth of Pen	e survey, Civil Right d a complaint surve 2023, it was determ nd Rehabilitation Ce the following requi part B, Requirements ties and the 28 PA C nsylvania Long Ter	ts y ined that enter was rements of s for Code,	F 0000			
SS=D	F 0625				F 0625			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE: (X6) DATE:		DIDECTORIS OF BRAVINER (SURN) I	ED DEDDECENITATINES SIGN	ATIDE		TITLE:	NO DUTTE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 1 of 76

	MENT OF DEFICIENCIES AND OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBE 395398			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 05/18/2023	
NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHABILITATION CENTER STATE LICENSE NUMBER: 970202			STREET ADDRESS 228 SIEMON SOMERSET,	DRIVE	IP CODE:		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH D MUST BE PRECEEDED BY FULL REGULATORY (IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0625 SS=D	Continued from page 1 483.15(d)(1)(2) Notice of B Trnsfr §483.15(d) Notice of bed-ho §483.15(d) Notice before facility transfers a resident t goes on therapeutic leave, th written information to the re representative that specifies (i) The duration of the state which the resident is permit residence in the nursing faci (ii) The reserve bed paymen § 447.40 of this chapter, if a (iii) The nursing facility's po periods, which must be cons this section, permitting a res (iv) The information specific section. §483.15(d)(2) Bed-hold not transfer of a resident for hos leave, a nursing facility must the resident representative w the duration of the bed-hold	transfer. Before a nursice a hospital or the resident enursing facility must sident or resident bed-hold policy, if any, and to return and resume lity; to policy in the state plar ny; blicies regarding bed-ho istent with paragraph (edient to return; and ed in paragraph (e)(1) of the company of the pitalization or therapeur to provide to the resident viritten notice which specifical and returns and the pitalization or the resident viritten notice which specifical and returns and the pitalization or the resident viritten notice which specifical and returns a n	ng ent provide during en, under ld e)(1) of f this etime of tic e and cifies	F 0625	Business Office Manager and Worker were educated by the Executive Director on the beletter and bedhold process. Resident 59 and their representative/next of kin wanotified about the facility's believe by the Social Worker. Licensed staff were educated Director of Nursing on 6/8/2 the bedhold policy and about bedhold policy binder to be pat the nurses' station. The Bedhold Policy binder we placed at the nurses' station where the station of the transfer to the hospital. The Worker reviews the binder to a resident who just left had a bedhold notification sent. There will be a review of the residents transferred with More reviews the binder to the residents transferred with More reviews the binder to the station sent.	e sidhold as then sedhold d by the o23 on the placed was with time of Social consure of social consure of sedicaid	Completion Date: 06/09/2023 Status: APPROVED Date: 06/08/2023
	(d)(1) of this section. This REQUIREMENT is no	t met as evidenced by:			to ensure that they received by notification 5 times a week f weeks then monthly for 2 mc. The results of this review wi	for 4 onths.	

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 2 of 76

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:			PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395398			· -	05/18/2023	
NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHABILITATION CENTER STATE LICENSE NUMBER: 970202		ABILITATION	STREET ADDRESS, 228 SIEMON I SOMERSET, I	DRIVE	IIP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF TAG IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0625	Continued from page 2			F 0625			
SS=D					reported by Social Services a monthly Quality Assurance Performance Improvement N		

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 3 of 76

	F OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER. ORRECTION (POC) IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		395398			_00	05/18/2023	
SOMERSE CENTER	VIDER OR SUPPLIER: T HEALTHCARE & REH E NUMBER: 970202	ABILITATION	STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	ZIP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0625	Continued from page 3			F 0625			
SS=D							
	Based on review of clin	nical records, as wel	l as staff				
	interviews, it was deter		-				
	to ensure that the reside	-					
	was notified about the		-				
	upon transfer to the hospital for one of 38 residents reviewed (Resident 59).						
	Findings include:						
	A quarterly Minimum	Data Set (MDS) ass	essment				
	(a mandated assessmen	nt of a resident's abil	ities and				
	care needs) for Resider						
	revealed that the reside	-	-				
	required extensive assistand had diagnoses that	-					
	and chronic kidney dise		lemus				
	Nurse's notes for Resid		-				
	2023, at 7:25 p.m. reve						
	admitted to the hospita	i for a change in cor	iaition.				
	There was no documen	nted evidence that th	e				

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 4 of 76

STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/CLI PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:		
		395398			00	05/18/2023	
SOMERSE CENTER	NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHABILITATION CENTER STATE LICENSE NUMBER: 970202			CITY, STATE, Z DRIVE PA 15501	MP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIE) PREFIX MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0625	Continued from page 4			F 0625			
SS=D	resident and/or the respanding the facility's bedabove transfer to the hole. Interview with the Nur May 17, 2023 at 9:26 a was no documented evwas issued to Resident and that it should have 28 Pa. Code 201.29(d) 28 Pa. Code 211.5(f) Code 211.5(f) Code 201.29(d)	chold policy at the tipospital for Resident sing Home Administrum, confirmed that tidence that a bed ho 59 or his responsible been. Resident rights.	me of the 59. strator on there ld notice				
F 0641				F 0641			
SS=D							

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 5 of 76

	ENT OF DEFICIENCIES AND CORRECTION (POC) (XI) PROVIDER/SUPPLIEF IDENTIFICATION NUMBI				PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395398				05/18/2023	
SOMERSE CENTER	VIDER OR SUPPLIER: THEALTHCARE & REH E NUMBER: 970202	ABILITATION	STREET ADDRESS 228 SIEMON SOMERSET,	DRIVE	IP CODE:		
(X4) ID PREFIX TAG	4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DI EFIX MUST BE PRECEEDED BY FULL REGULATORY OF			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0641 SS=D	Continued from page 5 483.20(g) Accuracy of Assessment must accurate status. This REQUIREMENT is not	sessments. Itely reflect the resident	S	F 0641	Resident #18's MDS (aka M Data Set) assessment was mat the time of survey to show use. Resident #8's MDS assess was modified to code influer vaccine as none of the above instead of refused. Resident MDS assessment was modificorrect insulin and diuretics. Resident # 25's MDS assess was modified to correct diur anticoagulants. Resident #1' assessment was modified to bowel incontinence. An initial audit was conductive residents last MDS assessment was modified to bowel incontinence. 1. Oxygen-use while or while resident. 2. Influenza Vaccine-consensor refuse 3. Medications-insulin/anticoaguments.	odified v oxygen essment nza e #80's fied to ment etics/ 7's MDS correct ed on all ents to oded de not a tt, decline	Completion Date: 06/09/2023 Status: APPROVED Date: 06/08/2023
					diuretics days recorded use. Registered Nurse Assessmen	nt	

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 6 of 76

	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 395398		A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED: 05/18/2023	Y
SOMERSE' CENTER	//IDER OR SUPPLIER: T HEALTHCARE & REH	ABILITATION	STREET ADDRESS, 228 SIEMON I SOMERSET,	DRIVE	IP CODE:		
STATE LICENSE NUMBER: 970202 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0641 SS=D	Continued from page 6			F 0641	Coordinators (RNACS) were educated by the Vice Preside Clinical Services on the proposition of the MDS. RNACs also check each other's coding accuracy prior to MDS submitted accuracy and proper coding of oxygen, influenza medication bowel continence weekly for then monthly for 2 months be RNACs. This will then be reby the RNAC at the monthly Assurance Performance Improvement Meeting.	ent of per s will ag for uission. I for of ns, and t 4 weeks y the eported	

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 7 of 76

***************************************					(X3) DATE SURVI COMPLETED:	ΕY
	395398				05/18/2023	
T HEALTHCARE & REH	ABILITATION	228 SIEMON	DRIVE	IP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE			ID PREFIX TAG	CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETE DATE
Instrument User's Man well as staff interviews facility failed to compl Set assessments for for (Residents 8, 18, 25, 8). Findings include: The Long-Term Care I Instrument (RAI) User guidance and instruction Minimum Data Set (Massessments of a resided dated October, 2019, in Section O was to recomprograms that were protected the seven-day lookback was to be coded with the vaccine was not received.	ual and clinical recos, it was determined the ete accurate Minimular of 38 residents revolution. Facility Resident Associated the completion of the completion of the completion of the ethical special treatments ovided to the resident of the reason the influenced.	rds, as that the im Data riewed sessment ovides on of andated e needs), ent of and t during 0250C	F 0641			
A quarterly MDS asses	ssment for Resident	8, dated				
	VIDER OR SUPPLIER: T HEALTHCARE & REH ENUMBER: 970202 SUMMARY STATEMENT MUST BE PRECEEDED IDENTIFY Continued from page 7 Based on a review of the Instrument User's Man well as staff interviews facility failed to comple Set assessments for for (Residents 8, 18, 25, 86) Findings include: The Long-Term Care For Instrument (RAI) User guidance and instruction Minimum Data Set (Massessments of a resided dated October, 2019, in Section O was to recomprograms that were programs that were programs that were programs that were programs to be coded with the vaccine was not received.	Based on a review of the Resident Assessm Instrument User's Manual and clinical recowell as staff interviews, it was determined facility failed to complete accurate Minimu Set assessments for four of 38 residents rev (Residents 8, 18, 25, 80). Findings include: The Long-Term Care Facility Resident Ass Instrument (RAI) User's Manual, which proguidance and instructions for the completic Minimum Data Set (MDS) assessments (massessments of a resident's abilities and cardated October, 2019, indicated that the interviews programs that were provided to the resident the seven-day lookback period. Section Of was to be coded with the reason the influer vaccine was not received.	VIDER OR SUPPLIER: THEALTHCARE & REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 7 Based on a review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate Minimum Data Set assessments for four of 38 residents reviewed (Residents 8, 18, 25, 80). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides guidance and instructions for the completion of Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October, 2019, indicated that the intent of Section O was to record special treatments and programs that were provided to the resident during the seven-day lookback period. Section O0250C was to be coded with the reason the influenza	A BLDG: 395398 STREET ADDRESS, CITY, STATE, Z 228 SIEMON DRIVE SOMERSET, PA 15501 ENUMBER: 970202 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 7 F 0641 Based on a review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate Minimum Data Set assessments for four of 38 residents reviewed (Residents 8, 18, 25, 80). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides guidance and instructions for the completion of Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October, 2019, indicated that the intent of Section O was to record special treatments and programs that were provided to the resident during the seven-day lookback period. Section O0250C was to be coded with the reason the influenza vaccine was not received.	DENTIFICATION NUMBER: 395398 A BLDG	DENTIFICATION NUMBER: 395398 DENTIFICATION NUMBER: 395398 STREET ADDRESS. CITY, STATE, JP CODE: 28 SIEMON DRIVE SOMERSET, PA 15501

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 8 of 76

					(X3) DATE SURVI COMPLETED:	EΥ
	395398				05/18/2023	
	ABILITATION	228 SIEMON	DRIVE	MP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE			ID PREFIX TAG	CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETE DATE
usually understood and others, required extensihis daily care tasks, and included dysarthria (sp muscle weakness). See the resident was offered vaccine. An Informed Consent of Resident 8, dated Dece that the resident gave of influenza vaccine. The evidence that the resident influenza vaccine. The RAI User's Manual revealed that Section Cofor the resident's special and programs. Section for the use of oxygen. checked if oxygen was	I could usually underive assistance from a dead a diagnosis that eech disorder caused tion O0250C revealed but declined the information Influenza Vaccine and the end of the end	rstand staff for at d by ed that afluenza he form for caled e ted ed the 19, hpleted lures, coded be sident of	F 0641			
the facility within the li	asi 14 days, and con	uniii (<i>2)</i>				
	VIDER OR SUPPLIER: T HEALTHCARE & REH E NUMBER: 970202 SUMMARY STATEMENT MUST BE PRECEEDE IDENTI Continued from page 8 February 28, 2023, ind usually understood and others, required extens his daily care tasks, and included dysarthria (sp muscle weakness). See the resident was offere vaccine. An Informed Consent to Resident 8, dated Dece that the resident gave of influenza vaccine. The evidence that the reside influenza vaccine. The RAI User's Manual revealed that Section Co for the resident's special and programs. Section for the use of oxygen. checked if oxygen was	WIDER OR SUPPLIER: THEALTHCARE & REHABILITATION ENUMBER: 970202 SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY OF IDENTIFYING INFORMATION) Continued from page 8 February 28, 2023, indicated that the residu usually understood and could usually under others, required extensive assistance from this daily care tasks, and had a diagnosis the included dysarthria (speech disorder caused muscle weakness). Section O0250C reveal the resident was offered but declined the invaccine. An Informed Consent for Influenza Vaccine. Resident 8, dated December 27, 2022, revet that the resident gave consent to receive the influenza vaccine. There was no documen evidence that the resident declined or refusinfluenza vaccine. The RAI User's Manual, dated October 20 revealed that Section O0100 was to be comfor the resident's special treatments, proceed and programs. Section O0100C was to be for the use of oxygen. Column (1) was to be checked if oxygen was used while not a resident as the resident of the resident oxygen. Column (1) was to be checked if oxygen was used while not a resident of the resident oxygen.	WIDER OR SUPPLIER: THEALTHCARE & REHABILITATION SOMERSET, SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 8 February 28, 2023, indicated that the resident was usually understood and could usually understand others, required extensive assistance from staff for his daily care tasks, and had a diagnosis that included dysarthria (speech disorder caused by muscle weakness). Section O0250C revealed that the resident was offered but declined the influenza vaccine. An Informed Consent for Influenza Vaccine form for Resident 8, dated December 27, 2022, revealed that the resident gave consent to receive the influenza vaccine. There was no documented evidence that the resident declined or refused the	A BLDG: B. WING: STREET ADDRESS, CITY, STATE, 228 SIEMON DRIVE SOMERSET, PA 15501 ENUMBER: 970202 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 8 Fobruary 28, 2023, indicated that the resident was usually understood and could usually understand others, required extensive assistance from staff for his daily care tasks, and had a diagnosis that included dysarthria (speech disorder caused by muscle weakness). Section O0250C revealed that the resident was offered but declined the influenza vaccine. An Informed Consent for Influenza Vaccine form for Resident 8, dated December 27, 2022, revealed that the resident gave consent to receive the influenza vaccine. There was no documented evidence that the resident declined or refused the influenza vaccine. 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CITY, STATE, ZIP CODE. 228 SIEMON DRIVE SOMERSET, PA 15501 FOOTOMERSET, PA 15501 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE Continued from page 8 FOOTOMING FROM THE CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE February 28, 2023, indicated that the resident was usually understood and could usually understand others, required extensive assistance from staff for his daily care tasks, and had a diagnosis that included dysarthria (speech disorder caused by muscle weakness). Section 00250C revealed that the resident was offered but declined the influenza vaccine. An Informed Consent for Influenza Vaccine form for Resident 8, dated December 27, 2022, revealed that the resident gave consent to receive the influenza vaccine. The RAI User's Manual, dated October 2019, revealed that the resident declined or refused the influenza vaccine. The RAI User's Manual, dated October 2019, revealed that Section 00100C was to be conded for the use of oxygen. Column (1) was to be checked if oxygen was used while not a resident of

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 9 of 76

STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:		
		395398		A. BLDG: _ B. WING: _		05/18/2023	
SOMERSE CENTER	VIDER OR SUPPLIER: THEALTHCARE & REH SE NUMBER: 970202	ABILITATION	STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	MP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DI PREFIX MUST BE PRECEEDED BY FULL REGULATORY C IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0641	Continued from page 9			F 0641			
SS=D	was to be checked if or resident of the facility. Physician's orders for I 2023, included an order continuous oxygen at 2 via nasal cannula (tuber nostrils) and to titrate (needed to ensure that the concentration/pulse ox in blood) was equal to every shift. The reside Administration Record 2023 indicated that the 2 liters per minute. Ho assessment for Resider revealed that Section Cochecked to indicate that during the 14-day assessment for Resider revealed that Section Cochecked to indicate that during the 14-day assessment for Resider revealed that Section Cochecked to indicate that during the 14-day assessment for Resider revealed that Section Cochecked to indicate that during the 14-day assessment for Resider revealed that Section Cochecked to indicate that during the 14-day assessment for Resider revealed that Section Cochecked to indicate that during the 14-day assessment for Resider revealed that Section Cochecked to indicate that during the 14-day assessment for Resider revealed that Section Cochecked to indicate that during the 14-day assessment for Resider revealed that Section Cochecked to indicate that during the 14-day assessment for Resider revealed that Section Cochecked to indicate that during the 14-day assessment for Resider revealed that Section Cochecked to indicate that during the 14-day assessment for Resider revealed that Section Cochecked to indicate that during the 14-day assessment for Resider revealed that Section Cochecked to indicate that during the 14-day assessment for Resider revealed that Section Cochecked to indicate that during the 14-day assessment for Resider revealed that Section Cochecked to indicate that during the 14-day assessment for Resider revealed that Section Cochecked to indicate that during the 14-day assessment for Resider revealed that Section Cochecked to indicate that during the 14-day assessment for Resider revealed that Section Cochecked to indicate that during the 14-day assessment for Resider revealed that Section Cochecked to indicate that during the 14-	Resident 18, dated Jacr for the resident to 2 liters per minute (files that deliver oxyge (adjust the flow rate) the oxygen imetry (percentage of or greater than 90 perts Medication Is (MAR's) for April excession and the tresident used oxygen over a quarterly Mat 18, dated May 4, 200100C, Column 2 was the resident used of sement period.	anuary 6, receive low rate) in into the as of oxygen ercent and May en daily at MDS 2023, was not oxygen erc.				

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 10 of 76

	EMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/C OF CORRECTION (POC) IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
	395398					05/18/2023	
NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHABILITATION CENTER STATE LICENSE NUMBER: 970202			STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	MP CODE:		
(X4) ID		OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORRE	CTION (EACH	(X5)
PREFIX TAG	MUST BE PRECEEDE	ED BY FULL REGULATORY OF FYING INFORMATION)		PREFIX TAG	CORRECTIVE ACTION SHE	OULD BE	COMPLETE DATE
F 0641	Continued from page 10			F 0641			
SS=D	coded correctly on Res of May 4, 2023. The RAI User's Manual indicated that the intenrecord the number of dinsulin during the sever intent of Section N0410 of days the resident record the number of dring period. The intent of Section the number of dring diuretic (increases the abody) during the seven Physician's orders for February November 25, 2022, in resident to receive 5 manticoagulant) two times 2023 MAR for Resider resident was given Elicitook-back period. The	al, dated October 201 t of Section N0350A ays the resident rece n-day look-back per 0E was to record the reived an anticoagula the seven-day look-b ection N0410G was ays the resident rece amount of urine mac and look-back perior Resident 25, dated acluded an order for illigrams (mg) of El es a day. Review of at 25 revealed that the quis seven days during re was no document	19, A was to eived iod. The e number ant back is to eived a de by the od. the iquis (an i the May ne ng the				
	evidence that a diuretic	waiminiotorou.					

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 11 of 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIED IDENTIFICATION NUMBER			A (X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:		
		395398			00	05/18/2023	
SOMERSE CENTER	VIDER OR SUPPLIER: T HEALTHCARE & REH E NUMBER: 970202	ABILITATION	STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	ZIP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE
F 0641 SS=D	A quarterly MDS for R 2023, revealed that the and able to understand with daily care needs, a included Down Syndro coded as (0), indicating an anticoagulant during Section N0410G was cresident received a diur look-back period. A quarterly MDS for R 22, 2023, revealed that intact, required superviand had diagnoses that N0350A was coded as received insulin seven period. Section N0410 indicating the resident during the look-back period.	resident was undersothers, required supand had diagnoses theme. Section N04101 of the resident did not gethe look-back perioded as (7), indicativation of the resident was considered diabetes. (7), indicating the redays during the look of was coded as (7), received a diuretic suparticular to the resident was considered.	estood bervision nat E was t receive od. ng the ing the ebruary gnitively needs, Section esident x-back	F 0641			

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 12 of 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		395398			00	05/18/2023	
NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHABILITATION CENTER STATE LICENSE NUMBER: 970202			STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	MP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH D PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE
F 0641	Continued from page 12			F 0641			
SS=D	There was no documented evidence that Resident 80 had a physician's order for insulin or a diuretic, and a review of the MAR for Resident 80 for February 2023 revealed no documentation that the resident received insulin or a diuretic during the seven-day look-back period. An interview with the Nursing Home Administrator on May 18, 2023, at 10:55 a.m. confirmed that the above-mentioned MDS assessments for Residents 8, 25, and 80 were coded incorrectly.		liuretic, For that the g the inistrator that the				
F 0657				F 0657			
SS=D							

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 13 of 76

STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/C PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER					(X3) DATE SURVEY COMPLETED:		
					00	05/18/2023	
		395398		B. WING.		03/16/2023	
	VIDER OR SUPPLIER: CT HEALTHCARE & REH	ABILITATION	STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	IIP CODE:		
STATE LICENS	SE NUMBER: 970202						
(X4) ID PREFIX TAG	PREFIX MUST BE PRECEEDED BY FULL REGULATORY (TAG IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0657	Continued from page 13			F 0657			
SS=D							
22=D	483.21(b)(2)(i)-(iii) Care Plas 483.21(b) Comprehensive §483.21(b)(2) A comprehen (i) Developed within 7 days comprehensive assessment. (ii) Prepared by an interdisc is not limited to(A) The attending physician (B) A registered nurse with (C) A nurse aide with respon (D) A member of food and I (E) To the extent practicable resident and the resident's reexplanation must be include if the participation of the resident (F) Other appropriate staff of determined by the resident's resident. (iii)Reviewed and revised by each assessment, including a quarterly review assessment.	Care Plans asive care plan must be- after completion of the iplinary team, that inclu responsibility for the resident nutrition services staff. e, the participation of the expresentative(s). An ad in a resident's medical sident and their resident I not practicable for the 's care plan. or professionals in discip needs or as requested b by the interdisciplinary te both the comprehensive is.	des but sident. e I record olines as y the		Resident # 25's care plan wa reviewed and revised for risk vein thrombosis (aka DVT) a interventions were put into p Elopement interventions were reviewed and revised by the (aka Registered Nurse Asses Coordinator) and added to the plan. Resident #35's tube fee care plan was revised by the to discontinue the tube feeding were reviewed to ensure that a rese was completed on inactive conditions and appropriate interventions are in place and documented by the IDT team. Nursing staff were educated Vice President of Clinical See on updating care plans to ensure that a resolving plans and interventions. Nurstaff were also educated, by Director of Nursing/designed performing interventions that the plan of care and documents.	k of deep and blace. re also RNAC ssment ne care eding RNAC ng. ent, solution d n. by the ervices ssure ng care sing the e, on ut are in	Completion Date: 06/02/2023 Status: APPROVED Date: 06/08/2023

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 14 of 76

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
	395398			A. BLDG:00_ B. WING:		05/18/2023	
SOMERSET HEALTHCARE & REHABILITATION 228 S			STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	MP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIE PREFIX MUST BE PRECEEDED BY FULL REGULATORY OR LSC TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0657	Continued from page 14			F 0657			
SS=D		ilitarati kanjalalin	the at the state of the state o		of interventions. As residents needs changes, care plans will be updated w new information and review needed to ensure that resolut interventions and following interventions with document residents that have an ARD (Assessment Review Date) for week or a change in condition IDT (aka Interdisciplinary T4 weeks then monthly for 2 to This will be updated in our Fand Procedure on care plann will follow our Policy and Procedure and Procedure on Policy and Procedure on Care plann will follow our Policy and Procedure	ith their ed as ition, attion on (aka or the on by the eam) for months. Policy ing and	
F 0684 SS=D				F 0684			

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 15 of 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBE 395398			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 05/18/2023		
SOMERSE CENTER	VIDER OR SUPPLIER: THEALTHCARE & REH SE NUMBER: 970202	ABILITATION	STREET ADDRESS. 228 SIEMON SOMERSET,	DRIVE	TIP CODE:		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY IDENTIFYING INFORMATION)			ID PREFIX TAG	THO TIBER OT ESTATE OF CONTROL (E.		(X5) COMPLETE DATE
F 0684 SS=D	Continued from page 15 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundame treatment and care provided the comprehensive assessme must ensure that residents re accordance with professiona comprehensive person-cente residents' choices. This REQUIREMENT is no	I to facility residents. Ba ent of a resident, the fac eceive treatment and car al standards of practice, ered care plan, and the	ised on ility e in	F 0684	Resident # 25's orders and Medication Administration I were reviewed and tubigrips applied as per the physician's Resident's #77's physician or and Medication Administrat Record were reviewed, and I was assessed for any ill effect the physician was notified or missing medication on 4/7/2 4/14/23, and 4/18/23. Audit completed on all resid with tubigrips to ensure that physician's order is in place. medication administration at baseline audit) of all resident determine if there are any of missed medications. Licensed nursing staff were educated to ensure that phys order for tubigrips is in place licensed nursing staff re-edu on medication administration documentation. Audit treatment records to be completed by Director of	s were s order. rders ion resident ets and f the i.3, lents Daily udit (aka tts to ther dician's e. All leated n and	Completion Date: 06/02/2023 Status: APPROVED Date: 06/08/2023

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 16 of 76

	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 395398		A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED: 05/18/2023	YY .
NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHABILITATION CENTER STATE LICENSE NUMBER: 970202			STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	IP CODE:		
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F 0684 SS=D	Continued from page 16			F 0684	Nursing/designee daily times weeks then weekly times 2 w then monthly times 2 months medication administration au (aka baseline audit) will cont be completed on all residents determine if there are any oth missed medications. All of the findings will be reported by the Director of Nursing at the medical Quality Assurance Performant Improvement meeting.	veeks s. Daily adits sinue to s to ner ne the onthly	

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 17 of 76

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 395398		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 05/18/2023	
NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHABILITATION CENTER STATE LICENSE NUMBER: 970202			STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	IIP CODE:		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0684 SS=D	Based on review of clininterviews, it was deter to ensure that physician were followed for two (Residents 25, 77). Findings include: An Admission Minimulassessment (a mandate abilities and care needs 14, 2023, revealed that and able to understand with daily care needs, a included Down's Syndin Physician's orders for I 30, 2022, included and wear tubigrip (elastic becompression to reduce extremities from toe to	rmined that the facilian's orders for medical of 38 residents reviews and Data Set (MDS) dissessment of a resident 25, do the resident was unothers, required suppand had diagnosis the rome. Resident 25, dated A order for the resident provide swelling) to bilatera	sident's ated May derstood pervision atugust at to s al lower	F 0684			
	off every evening for e		-				

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 18 of 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBER:				(X2) MULTI	PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	EY			
	395398			A. BLDG: _ B. WING: _		05/18/2023				
		395398		D. WING		03/10/2023				
	VIDER OR SUPPLIER: T HEALTHCARE & REH	ADII ITATION	STREET ADDRESS, CITY, STATE, ZIP CODE: 228 SIEMON DRIVE							
CENTER	I HEALTHCAKE & KEH	ABILITATION	SOMERSET,							
	050202									
STATE LICENS (X4) ID	E NUMBER: 970202	OF DEFICIENCIES (EACH DE	FICIENCY	ID	DROVIDEDIC DI AN OF CORDE	CTION (EACH	(X5)			
PREFIX	MUST BE PRECEEDE		PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH		COMPLETE				
TAG	IDENTII	FYING INFORMATION)			CROSS-REFERENCED TO THE A	APPROPRIATE	DATE			
F 0684	Continued from page 18			F 0684						
aa D										
SS=D	Resident 25's potential	for impaired skin in	togrity							
	care plan, dated April									
	intervention to use tubi									
	extremities from toe to	• 1								
	off every evening for e	•	ining unu							
	off every evening for e	doma.								
	Review of the Medicat	ion Administration l	Records							
	(MAR) for Resident 25	for April and May	2023							
	revealed no documente									
	worn on the resident as		C 1							
	Observations on May 1	6, 2023, at 1:52 p.m	1.							
	revealed that Resident	25 sitting in his whe	elchair in							
	his room wearing socks	s and sneakers. The	re were							
	no tubigrip or compres	sion stockings of an	y kind on							
	his legs. An interview	with the Director of	Nursing							
	at that time confirmed that the resident was not									
	wearing tubigrip.									
	Interview with the Director of Nursing on May 17,		-							
	2023, at 11:18 p.m. con									
	a physician's order to w									
	lower legs; however, th	nere was no docume	nted							

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 19 of 76

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		(X2) MULTI	(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
	395398			A. BLDG:00_ B. WING:		05/18/2023		
NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHABILITATION CENTER STATE LICENSE NUMBER: 970202			STREET ADDRESS, 228 SIEMON I SOMERSET,	DRIVE	IIP CODE:			
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0684	Continued from page 19			F 0684				
SS=D	evidence in the previous resident had worn the to resident had worn the to A quarterly MDS assess dated February 22, 2022 was sometimes understand, and had a comparent with the thyroid gland thyroid hormones to more a plan for the residence revealed that the residence staff was to give the rest therapy as ordered.	ssment for Resident 23, revealed that the tood, could sometim diagnosis of hypothyd does not make endet your body's need ent, dated February 2 ent had hypothyroidi	77, resident es vroidism ough ls). A 1, 2023, sm and					
	Physician's orders for Resident 77, dated April 4, 2023, included an order for the resident to receive one 175 microgram (mcg) tablet of Levothyroxine (a medicine used to treat an underactive thyroid gland (hypothyroidism) every morning. A review of the April 2023 MAR's for Resident 77 revealed that there was no documented evidence that the resident was administered the 175 mcg							

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 20 of 76

STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/C PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER:				IPLE CONSTRUCTION:	UCTION: (X3) DATE SURVEY COMPLETED:		
395398		395398		A. BLDG: <u>00</u> B. WING:		05/18/2023	
NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHABILITATION CENTER STATE LICENSE NUMBER: 970202			STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	ZIP CODE:		
	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH)			ID	PROVIDER'S PLAN OF CORREC	CTION (FACH	(X5)
PREFIX TAG	MUST BE PRECEEDE IDENTII		PREFIX TAG	CORRECTIVE ACTION SHE	OULD BE	COMPLETE DATE	
F 0684	Continued from page 20			F 0684			
SS=D	tablet of Levothyroxino 2023. Interview with the Ass May 18, 2023, at 10:45 was no documented ev administered the 175 m on April 7, 14, and 18, 28 Pa. Code 211.12(d)	istant Director of No 5 a.m. confirmed that idence that Resident acg tablet of Levothy 2023.	ursing on t there t 77 was yroxine				
F 0686				F 0686			
SS=D							

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 21 of 76

	TEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIE IN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIE IDENTIFICATION NUMB			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 05/18/2023	
		395398	B. WING 05/18/2025				
NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHABILITATION CENTER STATE LICENSE NUMBER: 970202		ABILITATION	STREET ADDRESS 228 SIEMON SOMERSET,	DRIVE	CIP CODE:		
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION SHOULD SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION SHOULD SHOU		OULD BE	(X5) COMPLETE DATE
F 0686 SS=D	Continued from page 21 483.25(b)(1)(i)(ii) Treatmer Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulce Based on the comprehensive facility must ensure that- (i) A resident receives care, standards of practice, to pre not develop pressure ulcers condition demonstrates that (ii) A resident with pressure treatment and services, constandards of practice, to pro and prevent new ulcers from This REQUIREMENT is not	rs. e assessment of a resider consistent with professi vent pressure ulcers and unless the individual's c they were unavoidable; culcers receives necessa sistent with professional mote healing, prevent in n developing.	nt, the ional does blinical and ary	F 0686	Resident #35's wound was a by the wound nurse on 5/18/ Interventions for residents ic as having the potential to be affected: 1. A skin sweep will be com all residents and any areas/blemishes will be reco. 2. Nurse aides to be educated shower sheets and marking a whether old or new. If areas they must be verbally reportenurse including but not limit bruises. Nurse aides to also educated on preventable skin interventions. 3. Licensed staff and therapy educated on new skin areas including bruises. New skin any nature must have a non-incident report and investigated completed. 4. Nurse/designee in charge program will see new area and stage of the	dentified pleted on rded. d on all areas s noted, ed to the ed to be n y to be area of fall tion	Completion Date: 06/09/2023 Status: APPROVED Date: 06/08/2023

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 22 of 76

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395398		B. WING:	IG: 05/18/2023		
NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHABILITATION CENTER STATE LICENSE NUMBER: 970202			STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	IP CODE:		
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F 0686	Continued from page 22		F 0686				
SS=D					admission or readmission withours -if a weekend, this will the following Monday. 5. Wound nurse to see all wo weekly, regardless of whom by the facility nurse practition wound clinic. 6. New areas will be discussed the IDT (Interdisciplinary Testhe weekly programs meeting Systematic Change: 1. Nurse/designee in charge of skin program will see new areany admission or re-admission within 24 hours-if a weekend occur on Monday. 2. New areas will be discussed the IDT in weekly programs 3. Director of Nursing/design complete wound rounds week document findings in the not the electronic medical records.	bunds, is seen oner or ed with eam) in g. of the rea and on d, it will ed with meeting.	

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 23 of 76

STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/A PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER			A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:		
		395398		B. WING: 05/18/2023			
NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHABILITATION CENTER STATE LICENSE NUMBER: 970202		STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	IP CODE:			
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F 0686	Continued from page 23		F 0686				
SS=D				Monitoring of the change to system compliance: 1. Director of Nursing/design audit 10 residents weekly to new areas are documented by clinical disciplines and all will be documented weekly to weeks then every other week weeks then monthly. 2. Findings will be reported to Director of Nursing to the Quasurance Performance Improvement Meeting for refrecommendations.	nee will ensure y all ounds for 4 a for 4		

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 24 of 76

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 395398		A. BLDG: _ B. WING: _		(X3) DATE SURVEY COMPLETED: 05/18/2023	
SOMERSE CENTER	VIDER OR SUPPLIER: THEALTHCARE & REH SE NUMBER: 970202		STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	IP CODE:		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0686 SS=D	Continued from page 24 Based on review of clin	nical records, as wel	l as staff	F 0686			
	Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that pressure ulcers were monitored for one of 38 residents reviewed (Resident 35).						
	Findings include:						
	A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 35, dated April 19, 2023, revealed that the resident was cognitively intact, required extensive assistance with daily care needs, and had diagnoses that included diabetes and the presence of open wounds.						
	A care plan for the pote integrity for Resident 3 indicated that the care weekly wound assessminclude the width, leng exudate, and any other observations for each a	and treatment include the service of	oled eation to sue,				

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 25 of 76

		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		395398			00.	05/18/2023	
SOMERSE CENTER	VIDER OR SUPPLIER: T HEALTHCARE & REH E NUMBER: 970202	ABILITATION	STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	IIP CODE:		
(X4) ID PREFIX TAG	PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE
F 0686 SS=D	Continued from page 25		F 0686				
	A review of Resident 3 nursing notes, physicia consultations, revealed that weekly wound ass care planned.	d clinic dence					
	A wound clinic consult revealed that the reside appointment scheduled	nt had a follow up	5				
	An interview with the Registered Nurse 1 on confirmed that weekly done in the facility. Thoutside wound clinic at resident's wound treatment.	15 p.m. were not ed by an					
	An interview with the 18, 2023, at 2:51 p.m. care plan indicated to cassessments, so they shape of the care plan indicated to cassessments.	confirmed that Residence complete weekly wo	lent 35's und				

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 26 of 76

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER	II) PROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395398			<u></u>	05/18/2023		
SOMERSE CENTER	VIDER OR SUPPLIER: T HEALTHCARE & REH E NUMBER: 970202	ABILITATION	STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	IP CODE:			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFI PREFIX MUST BE PRECEEDED BY FULL REGULATORY OR TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHIPS CROSS-REFERENCED TO THE ACTION OF T	OULD BE	(X5) COMPLETE DATE	
F 0686 SS=D	An interview with the lon May 18, 2023, at 8: was no documentation assessments for Reside	45 a.m. confirmed the of weekly wound ent 35.	hat there	F 0686				
F 0695 SS=E				F 0695				

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 27 of 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBE 395398			A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 05/18/2023		
SOMERSE CENTER	VIDER OR SUPPLIER: THEALTHCARE & REH SE NUMBER: 970202		STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	IIP CODE:		
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0695 SS=E	Continued from page 27 483.25(i) Respiratory/Trach § 483.25(i) Respiratory care and tracheal suctioning. The facility must ensure tha respiratory care, including t suctioning, is provided such professional standards of pr person-centered care plan, t preferences, and 483.65 of t This REQUIREMENT is no	e, including tracheostom t a resident who needs racheostomy care and tracare, consistent with actice, the comprehension he residents' goals and his subpart.	y care	F 0695	Resident #17's order was ent tubing change. The tubing we changed and dated right duri survey. Resident #17's order oxygen was changed and no oximeter was needed. Review of all residents on oximeter was needed. Review of all residents on oximeter tubing change was or and if applicable pulse oxim is being monitored by the Di Nursing. Tubing on all residusing oxygen were checked 5/19/2023 by nursing staff at appropriately. Licensed nursing staff educate the Director of Nursing on doxygen tubing. Pulse oxime obtained when titrating then documenting tube change an oximeter. Residents with a refor oxygen or new admit with will be reviewed at clinical remeeting to ensure orders are implemented and that docum is present by the clinical tear	was ing the r for xygen B to dered eter order irector of dents on nd dated ated by ating eter ad pulse new order th oxygen morning enentation	Completion Date: 06/09/2023 Status: APPROVED Date: 06/08/2023

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 28 of 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBE			(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:		
		395398		A. BLDG: _ B. WING: _	00.	05/18/2023	
SOMERSE CENTER	VIDER OR SUPPLIER: T HEALTHCARE & REH E NUMBER: 970202	ABILITATION	STREET ADDRESS, 228 SIEMON I SOMERSET, I	DRIVE	MP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICE PREFIX MUST BE PRECEDED BY FULL REGULATORY OR LEGAL TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0695	Continued from page 28			F 0695			
SS=E	Parada a fine a		baning d		Residents requiring pulse ox will be placed on the Medica Administration Record (MA the Director of Nursing will for holes in the MAR. Resid that are on continuous oxyge are stable will be reviewed be physician as needed. New orders for oxygen will be reviewed weekly for 4 weeks monthly for 2 months to ensure the oxygen tubing is changed documented and that the pulsoximeter is documented whe applicable for titration. This reviewed at the monthly Qua Assurance and Performance Improvement Meeting.	ation R) and monitor dents en that by the be s then ure that d and se en s will be	
F 0711	20)15:225:00:2117:11 2(0)	inditation and the form	÷O10dinrO1	F 0711			
SS=D							

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 29 of 76

PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER (IDENTIFICATION NUMBE 395398			A. BLDG:00_ B. WING:		(33) DATE SURVEY COMPLETED: 05/18/2023		
SOMERSI CENTER	IVIDER OR SUPPLIER: ET HEALTHCARE & REH SE NUMBER: 970202	ABILITATION	STREET ADDRESS 228 SIEMON SOMERSET	DRIVE	IIP CODE:		
(X4) ID		OF DEFICIENCIES (EACH DE	EEICIENCV	ID	DROVIDEDIC DI ANI OF CODDE	CTION (FACH	(X5)
PREFIX TAG	MUST BE PRECEEDE	ED BY FULL REGULATORY OF FYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETE DATE
F 0711	Continued from page 29			F 0711			
SS=D	483.30(b)(1)-(3) Physician	Visits - Review Care/No	otes/Order				Completion
					Resident #78's nurse practiti	oner's	Date:
§483.30(b) Physician Visits				notes were received on 5/18/	/23.	06/09/2023	
	The physician must-						Status:
§483.30(b)(1) Review the resident's total program of including medications and treatments, at each visit			of care,		Residents were reviewed to all nurse practitioner notes w		APPROVED Date:
					uploaded in the system for th	ne past	06/08/2023
	by paragraph (c) of this section;				six months.		
	§483.30(b)(2) Write, sign, a	and date progress notes a	at each		The nurse practitioner was e	ducated	
	visit; and				by the D.O.N. (aka Director Nursing) on documentation		
	§483.30(b)(3) Sign and date	e all orders with the exce	eption of		and notes to be provided to t		
	influenza and pneumococca				facility. The Medical records		
	administered per physician-		after an		DON an abtaining nates and	-	
	assessment for contraindica	tions.			DON on obtaining notes and uploading nurse practitioner		
	This REQUIREMENT is no	ot met as evidenced by:			into the electronic medical re		
		J			and to follow up if not receive	ving	
					notes with the DON.		
					Medical Records Director w		
					be notified of the nurse practivisit and will ensure the note		
					received in a timely manner		
					uploaded into the system.		
					Nurse practitioner visits and	notes	
					to be reviewed by the D.O.N		
					ensure notes are received and		
					uploaded in a timely manner	. The	

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 30 of 76

	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:			PLE CONSTRUCTION: 00	(X3) DATE SURVE COMPLETED:	EY
		395398			· -	05/18/2023	
SOMERSE CENTER	VIDER OR SUPPLIER: T HEALTHCARE & REH E NUMBER: 970202	ABILITATION	STREET ADDRESS, 228 SIEMON I SOMERSET, I	DRIVE	IIP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0711	Continued from page 30			F 0711			
SS=D					findings will be reported at the monthly Quality Assurance Performance Improvement n		

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 31 of 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395398			00	05/18/2023	
SOMERSE CENTER	VIDER OR SUPPLIER: T HEALTHCARE & REH E NUMBER: 970202	ABILITATION	STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	TIP CODE:		
(X4) ID PREFIX TAG	PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0711	Continued from page 31			F 0711			
SS=D							
	Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that the certified registered nurse practitioner wrote progress notes with each visit for one of 38 residents reviewed (Resident 78)						
	one of 38 residents reviewed (Resident 78). Findings include:						
	A nursing note for Res 2023, revealed that Cet Practitioner 4 (CRNP - advanced training and for treatment) saw the rounds. New orders we resident's coccyx (also wound cleanser, apply cover with border foam every two days and as 4's progress note for Res 6, 2023, did not include resident's wound to her	rtified Registered Not a registered nurse with authority to write resident during would be received to clear known as the tailbout triple antibiotic oint in, and change the dreneded. However, resident 78, dated Felle his assessment of the coccyx area.	urse with e orders and asse the e) with ament, essing CRNP bruary the				
	A nursing note for Res	ident 78, dated Febr	uary 13,				

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 32 of 76

STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/C PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER:				(X2) MULTI	IPLE CONSTRUCTION:	(X3) DATE SURVI COMPLETED:	EY
	395398				00	05/18/2023	
NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHABILITATION CENTER STATE LICENSE NUMBER: 970202			STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	ZIP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0711	Continued from page 32			F 0711			
SS=D	2023, revealed that CR during wound rounds. to cleanse the resident's lower and back part of sterile saline (sterile sa antibiotic ointment, corchange the dressing ev. Staff was to discontinuresident's right lateral rankle) and to her right documented evidence to 2023, progress note for clinical record. Interview with Registe of Nursing on May 17, confirmed that CRNP 4 February 6, 2023, did rathe resident's coccyx with documented evidence of 2023, in the resident's coccyx with the Direction of the company of the resident's coccyx with the Direction of the company of the resident's coccyx with the Direction of the company of the coccys with the Direction of the company of the coccys with the Direction of the coccys with the coccys with the Direction of the coccys with the coccys with the Direction of the coccys with the coccys with the Direction of the coccys with the Direction of the coccys with the coccys with the Direction of the coccys with the cocces with the coccys with the coccys with the coccys with the cocces with the coccys with the coccys with the coccys with the cocces with the coccys with the cocces with the cocces with the cocce	New orders were restricted in the hip bone) with restricted in the hip bone) with restricted in the hip bone) with restricted in the hip bone in the current treatment and leolus (outside particle). There was that CRNP 4's Februar Resident 78 was particle. When the control is note for Resident not include his assessment and that there of his note from Februar ecord.	ceived as the formal e an, and needed. ents to the art of the no ary 13, art of the Director 78 from sment of was no ruary 13,				

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 33 of 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBER				PLE CONSTRUCTION: 00	(X3) DATE SURVEY COMPLETED:		
		395398		B. WING:		05/18/2023	
SOMERSE CENTER	VIDER OR SUPPLIER: T HEALTHCARE & REH E NUMBER: 970202	ABILITATION	STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	IP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DI PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHIP CROSS-REFERENCED TO THE ACTION SHIP PROPERTY OF THE ACTION	OULD BE	(X5) COMPLETE DATE
F 0711 SS=D	Continued from page 33 2023, at 2:50 p.m. rever physician's office fax of 13, 2023, note from CF 28 Pa. Code 211.5(f) CF	over Resident 78's Fe RNP 4 today.		F 0711			
F 0730 SS=D				F 0730			

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 34 of 76

STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIE PLAN OF CORRECTION (POC) IDENTIFICATION NUMB				IPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:		
		395398				05/18/2023	
SOMERSE CENTER	VIDER OR SUPPLIER: THEALTHCARE & REH E NUMBER: 970202	ABILITATION	STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	JP CODE:		
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0730	Continued from page 34			F 0730			
SS=D	483.35(d)(7) Nurse Aide Pe §483.35(d)(7) Regular in-se The facility must complete a nurse aide at least once ever regular in-service education reviews. In-service training requirements of §483.95(g). This REQUIREMENT is no	ervice education. a performance review of 12 months, and must based on the outcome of must comply with the	f every provide		Nurse Aide 3 did not have the annual evaluation available. An audit tool using a tickler system was conducted by the Human Resources Director of to ensure that all other staff if evaluations were conducted required and will continue to completed as required. The Human Resources Direct other Department Managers re-educated on ensuring that of evaluations are completed due. Staff member evaluations due in the next 30 days will be at the Human Resources Direct ensure compliance. Human Resources will then monitor compliance for all annual evalue for the next 2 months. It will be reported at the month Quality Assurance Performa Improvement meeting.	file e on 6/5/23 member as o be etor and will be 100% d when ue, if any, udited by tor to for raluations Results ally	Completion Date: 06/09/2023 Status: APPROVED Date: 06/08/2023

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 35 of 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		395398			<u></u>	05/18/2023	
SOMERSE CENTER	VIDER OR SUPPLIER: T HEALTHCARE & REH E NUMBER: 970202	ABILITATION	STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	MP CODE:		
(X4) ID PREFIX TAG	PREFIX MUST BE PRECEEDED BY FULL REGULATORY (TAG IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0730 SS=D	Based on a list of nurse facility and their person interviews, it was deter to ensure that nurse aids were completed annual one of four nurse aides. Findings include: A review of the person revealed a hire date of performance evaluation 2023, and January 26, 2 no documented evidence performance evaluation in January 2022. Interview with the Direct May 17, 2023, at 1:55 was no documented evidence had an annual performance required in January 2020.	nnel files, as well as mined that the facil le performance evaluation and the hire reviewed (Nurse A January 11, 2007, was completed on Jan 2023. However, the ce that her annual in was completed as a sector of Human Server, confirmed that idence that Nurse A sance evaluation com	ity failed uations dates for ide 3). ide 3 with uary 12, ere was required vices on there ide 3	F 0730			

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 36 of 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395398		B. WING:		05/18/2023	
SOMERSE CENTER	NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHABILITATION CENTER STATE LICENSE NUMBER: 970202			CITY, STATE, Z DRIVE PA 15501	IP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DI PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF TRAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0730 SS=D	Continued from page 36 28 Pa. Code 201.14(a) 28 Pa. Code 201.18(b) 28 Pa. Code 201.20(a)	(1)(3)(e)(1) Manage	ment.	F 0730			
F 0755 SS=D				F 0755			

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 37 of 76

PLAN OF CORRECTION (POC)		IDENTIFICATION NUMBER:		A. BLDG: 00		COMPLETED:	
	395398 B. WING:		05/18/2023				
	VIDER OR SUPPLIER:		STREET ADDRESS		IP CODE:		
	T HEALTHCARE & REH	ABILITATION	228 SIEMON				
CENTER			SOMERSET	, PA 15501			
STATE LICENSI	E NUMBER: 970202						
(X4) ID PREFIX		OF DEFICIENCIES (EACH DE		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH		(X5) COMPLETE
TAG	MUST BE PRECEEDED BY FULL REGULATORY IDENTIFYING INFORMATION)		K LSC	TREFIX TAG	CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A		DATE
							<u> </u>
F 0755	Continued from page 37			F 0755			
00 P							
SS=D							0 14
	483.45(a)(b)(1)-(3) Pharmac				D :1 / // 20 1//00 M 1	- ,-	Completion Date:
	Srvcs/Procedures/Pharmacis	st/Records			Residents # 22 and #80 Med Administration Records were		06/09/2023
	§483.45 Pharmacy Services				reviewed with the narcotic sl		Status:
	The facility must provide ro		ugs and		5/19/23. Residents # 22 and		APPROVED
	biologicals to its residents, or				orders were changed to inclu		Date:
	agreement described in §483				signatures as per policy.		06/08/2023
	unlicensed personnel to adm	ninister drugs if State la	w				
	permits, but only under the g	general supervision of a	ı		Resident # 22 and #80's MA		
	licensed nurse.				narcotic sheets were reviewe	•	
					IDT (aka Interdisciplinary To	eam).	
	§483.45(a) Procedures. A fa				Licensed numering staff views		
	pharmaceutical services (inc the accurate acquiring, recei		assure		Licensed nursing staff were educated on documentation of	of as	
	administering of all drugs ar		the		needed medication on the	51 u 5	
	needs of each resident.	id biologicals) to inject			Medication Administration F	Record	
					(MAR) and narcotic sheet. I	Licensed	
	§483.45(b) Service Consulta	ation. The facility must	employ		nursing staff were also educa	ated to	
	or obtain the services of a lie	censed pharmacist who-	-		immediately report any prob		
					the narcotics sheet/medication		
	§483.45(b)(1) Provides cons	-	of the		administration record to the		
	provision of pharmacy servi	ces in the facility.			of Nursing or Executive Dire	ector.	
	§483.45(b)(2) Establishes a	system of records of rec	ceint and		Nurse managers will review	narcotic	
	disposition of all controlled	-	-		sheets 3 times a week for 4 v		
	enable an accurate reconcilia	_			ensure that medications are a	also	
					being documented on the MA	-	
	§483.45(b)(3) Determines the				the Director of Nursing and		
	that an account of all control	lled drugs is maintained	d and		monthly for 2 months. This		
	periodically reconciled.				reported by the Director of N	vursing	

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 38 of 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 395398		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 05/18/2023	
SOMERSE CENTER				CITY, STATE, Z DRIVE PA 15501	IIP CODE:		
STATE LICENSE NUMBER: 970202 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DI PREFIX MUST BE PRECEEDED BY FULL REGULATORY C IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0755	Continued from page 38			F 0755			
SS=D	This REQUIREMENT is no	ot met as evidenced by:			at the monthly Quality Assur Performance Improvement M		

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 39 of 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		395398		1	00	05/18/2023	
NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHABILITATION CENTER STATE LICENSE NUMBER: 970202			STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	XIP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DI PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF TRAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0755 SS=D	Continued from page 39			F 0755			
	Based on review of factorecords, as well as staff determined that the fact accountability for control the potential to be abuse reviewed (Residents 22). Findings include: A facility policy for my January 13, 2023, indicate documented as given administration as specific regulations. A significant change My assessment (a mandate abilities and care needs 2, 2023, revealed that the intact, required extension needs, and had diagnostic records.	f interviews, it was sility failed to maintage rolled medications (sed) for two of 38 respectively. Solution of 38 respectively. Solution dispensing the edication dispension of 38 respectively. Solution dispension dispension of 38 respectively. Solution dispension dispe	ain drugs with sidents g, dated drugs state MDS) sident's ated May nitively				
	Physician's orders for I	Resident 22, dated F	ebruary				

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 40 of 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
	395398 NAME OF PROVIDER OR SUPPLIER:				<u>uu</u>	05/18/2023	
NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHABILITATION CENTER STATE LICENSE NUMBER: 970202			STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	IIP CODE:		
(X4) ID	1	OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORREC	CTION (EACH	(X5)
PREFIX TAG	MUST BE PRECEEDE IDENTII	ED BY FULL REGULATORY OF FYING INFORMATION)		PREFIX TAG	CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE A	OULD BE	COMPLETE DATE
F 0755	Continued from page 40			F 0755			
SS=D	13, 2023, included order one 5-325 milligrams (Hydrocodone-Acetaminarcotic pain medication for severe pain. Review of Resident 22 form used to account for medication) for April 2 mg tablet of Hydrocodesigned-out by staff for on April 3, 7, 13, 14, 2 there was no document clinical record, includin Administration Record actually administered to medication was destroy. Physician's orders for I 31, 2023, included order a 12 microgram (mcg) controlled narcotic pain every three days for chemical record and the controlled narcotic pain every three days for chemical records.	mg) tablet of nophen (a controlled on) every six hours at a second of a controlled drug restor each dose of a controlled that or one-Acetaminophen administration to the fed evidence in the reng on the Medication (MAR), to indicate the medication or that yed for any reason. Resident 22, dated Jacets for the resident to per hour Fentanyl per medication) transder	cord (a antrolled an e 5-325 awas a resident owever, resident's an that staff at the anuary to receive atch (a dermally				

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 41 of 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
395398		395398		A. BLDG: _ B. WING: _	00.	05/18/2023		
NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHABILITATION CENTER STATE LICENSE NUMBER: 970202			STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	MP CODE:			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0755	Continued from page 41			F 0755				
SS=D	have a witness signature patch every three days. Review of the controlled 22 for April 2023 reveal hour Fentanyl patch was administration to the residence in the residence on the MAR, that there when the Fentanyl patch was no documented event Hydrocodone-Acetamical administered to Reside evidence of a witness spatch was disposed of. A quarterly MDS for Reconstruction and the supervision of the supervision o	ed drug record for Realed that one 12 mcg as signed out by staff esident on April 1, 7, ere was no document's clinical record, in was a witness signath was disposed of. Sing Home Administ p.m. confirmed that idence that doses of nophen were actuall nt 22 and no documing a disposed of the resident was confirmed that idence that doses of nophen were actuall nt 22 and no documing a disposed of the resident was confirmed that idence that doses of nophen were actually no documing nature when the Foresident 80, dated Feather resident was confirmed that the resident was con	esident g per ff for , 10, and nted ncluding ature strator on there dy ented entanyl					

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 42 of 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395398		B. WING:	<u></u>	05/18/2023	
NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHABILITATION CENTER STATE LICENSE NUMBER: 970202			STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	MP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY O				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO	*	(X5) COMPLETE
TAG		FYING INFORMATION)			CROSS-REFERENCED TO THE A	APPROPRIATE	DATE
F 0755	Continued from page 42			F 0755			
SS=D	and had diagnoses that included diabetes.						
	Physician's orders for I	Resident 80, dated A	pril 12,				
	2023, included an orde	r for the resident to	receive				
	0.5 milligrams (mg) of	• `					
	drug) every six hours a	s needed for anxiety	<i>'</i> .				
drug) every six hours as needed for anxiety. Review of the controlled drug record for Residen 80 for April 2023 indicated that a Clonazepam dowas signed out by staff on April 14, 2023, at 8:10 a.m.; April 18, 2023, at 8:00 a.m.; April 24, 2023 at 8:08 a.m.; and April 30, 2023, at 7:55 p.m. However, the resident's clinical record, including MAR and nursing notes, contained no documente evidence that the signed-out doses of Clonazepan were administered to the resident on these dates a times.			pam dose at 8:10 , 2023, m. luding the amented azepam				
Interview with the Nursing Home Administration May 18, 2023, at 11:00 a.m. confirmed that was no documented evidence in Resident 80 clinical records to indicate that the signed-out of Clonazepam mentioned above were admin			t there 0's out doses				

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 43 of 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395398				05/18/2023	
NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	IIP CODE:		
STATE LICENSE NUMBER: 970202							
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0755	Continued from page 43			F 0755			
SS=D	to the resident.						
	28 Pa. Code 211.9(h) F	harmacy services.					
	28 Pa. Code 211.12(d)	(1) Nursing services					
	28 Pa. Code 211.12(d)	(5) Nursing services					
F 0758				F 0758			
SS=D							

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 44 of 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		395398			00.	05/18/2023	
NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHABILITATION CENTER STATE LICENSE NUMBER: 970202			STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	MP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE		FICIENCY	ID	PROVIDER'S PLAN OF CORREC	CTION (FACH	(X5)	
PREFIX TAG				PREFIX TAG	CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	COMPLETE DATE
F 0758	Continued from page 44			F 0758			
SS=D	483.45(c)(3)(e)(1)-(5) Free:	from Linnaa Payahatran	io				Completion
	Meds/PRN Use	nom Omec Esycholop	ic		Resident #80's Clonazepam (anxiolytic) was discontinued		Date: 06/09/2023
	§483.45(e) Psychotropic Dr	ugs.			after a discussion with the pr		Status:
	§483.45(c)(3) A psychotrop				care physician.		APPROVED
	brain activities associated w	•			A 11	11. /1.	Date: 06/09/2023
	behavior. These drugs includrugs in the following category		0,		All residents will be reviewe attending physician that have	-	00/03/2023
	(i) Anti-psychotic;	ories.			new order for psychoactive	z nau a	
	(ii) Anti-depressant;				medication in the last week t	o ensure	
	(iii) Anti-anxiety; and				initial order was for 14 days and		
	(iv) Hypnotic				reviewed for continuation an		
					rationale as per our facility p	olicy	
	Based on a comprehensive a facility must ensure that	assessment of a resident	, the		and procedure.		
	racinty must ensure mat				Licensed nursing staff to be		
	§483.45(e)(1) Residents who	o have not used psychot	ropic		educated on any new psycho	active	
	drugs are not given these dr		-		medication must only be ord	ered for	
	necessary to treat a specific	condition as diagnosed	and		14 days and review rationale		
	documented in the clinical r	record;			continue usage by the Direct	or of	
					Nursing. New psychoactive	1	
	§483.45(e)(2) Residents wh		S		medication will be reviewed		
	receive gradual dose reducti				morning clinical meeting to a 14-day order was obtained.	ensure a	
	interventions, unless clinica to discontinue these drugs;	iry contraindicated, in a	n enort		14-uay oruci was obtained.		
	to discontinue these didgs,				New psychoactive medication	ns will	
	§483.45(e)(3) Residents do	not receive psychotropic	e drugs		be reviewed weekly by the D		
	pursuant to a PRN order unl				of Nursing to ensure a 14-da		
	necessary to treat a diagnose		it is		was obtained and that the rat	-	
	documented in the clinical r	•			to continue was obtained if		

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 45 of 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
	395398			A. BLDG: _ B. WING: _	00	05/18/2023	
NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHABILITATION CENTER STATE LICENSE NUMBER: 970202			STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	ZIP CODE:		
STATE LICENS (X4) ID		OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORRE	CTION (EACH	(X5)
PREFIX TAG	MUST BE PRECEEDE	ED BY FULL REGULATORY OF FYING INFORMATION)		PREFIX TAG	CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	COMPLETE DATE
F 0758	Continued from page 45			F 0758			
SS=D	§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:			applicable for 4 weeks, then for 2 months.	monthly		

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 46 of 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		395398		B. WING:		05/18/2023	
NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHABILITATION CENTER STATE LICENSE NUMBER: 970202			STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	CIP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DI PREFIX MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0758 SS=D	Based on facility policy and CMS (Centers for Medicare & Medicaid Services) guidelines, as well as clinical record reviews and staff interviews, it was determined that the facility failed to ensure that			F 0758			
	residents were free from unnecessary medication for one of 38 residents reviewed (Resident 80). Findings include:						
	A facility policy for Ps January 3, 2023, included anxiolytics (used to recept CMS guidelines und CMS guidelines included Regulations (CFR) 483 orders for psychotropic and behavior; includes to 14 days. Except as processed in the attending phypractitioner believes the as-needed order to be expected.	ctions of empted aindicated. ral eded mood re limited 3.45(e) g or the					

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 47 of 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI	(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
Tanto comments. (22)				A. BLDG: _				
		395398		B. WING: _		05/18/2023		
	VIDER OR SUPPLIER: T HEALTHCARE & REH	ABILITATION	STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	IIP CODE:			
STATE LICENSE NUMBER: 970202								
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DI PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0758	Continued from page 47			F 0758				
SS=D	he or she should document their rationale in the resident's medical record and indicate the duration for the as-needed order.							
	A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 80, dated February 22, 2023, revealed that the resident was cognitively intact, required supervision with daily care needs, and had diagnosis that included diabetes and anxiety.							
	Physician's orders for Resident 80, dated April 12, 2023, included that the resident receive 0.5 milligrams (mg) of Clonazepam (an anxiolytic) ever six hours as needed for anxiety until end of life.							
	A review of clinical records, including physician progress notes for Resident 80, revealed no documented rationale for the long-term use of Clonazepam as needed, as required by federal law. An interview with the Director of Nursing on May							

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 48 of 76

	MENT OF DEFICIENCIES AND OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395398		B. WING: _		05/18/2023	
SOMERSE CENTER	VIDER OR SUPPLIER: T HEALTHCARE & REH. E NUMBER: 970202	ABILITATION	STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	IIP CODE:		
(X4) ID		OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORREC	CTION (EACH	(X5)
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F 0758	Continued from page 48			F 0758			
SS=D	17 2022 + 11 10	° 14 44					
	17, 2023, at 11:18 a.m.						
	documented rationale f as-needed clonazepam	_					
	by a psychiatric consul		ysician or				
	by a psychiatric consur	tant.					
	28 Pa. Code 211.12(d)((5) Nursing services					
F 0760				F 0760			
SS=E							

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 49 of 76

PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 395398		A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURV COMPLETED: 05/18/2023	EY
SOMERSE CENTER	VIDER OR SUPPLIER: ET HEALTHCARE & REH	IABILITATION	STREET ADDRESS 228 SIEMON SOMERSET,	DRIVE	TIP CODE:		
STATE LICENSE NUMBER: 970202 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DIPPREFIX MUST BE PRECEEDED BY FULL REGULATORY OF TAG IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0760	Continued from page 49			F 0760			
SS=E	483.45(f)(2) Residents are In The facility must ensure that §483.45(f)(2) Residents are medication errors. This REQUIREMENT is not seem to be a see	nt its- free of any significant	Errors		Residents # 17 and #77 had following interventions com a. Med error corrected. b. Doctor notification. c. Family notification. d. Resident assessed for negroutcomes. e. Medication errors were cofor resident with insulin not administered. f. Medication error complete Synthroid duplicate order. Interventions for residents id as having the potential to be affected: 1. All medications review admin on 5/3/23 2. Medication errors companded and the potential to be affected: 3. Doctor notification 4. Family notification 5. All residents that receives cale insulin were reviewed ensure they are receiving appropriate coverage. Licented educated on documenting slisscale insulin and coverage.	ative ative completed ed for dentified deted ve sliding to ased staff	Completion Date: 06/09/2023 Status: APPROVED Date: 06/12/2023

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 50 of 76

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		395398		B. WING:			
SOMERSE CENTER	VIDER OR SUPPLIER: THEALTHCARE & REH SE NUMBER: 970202	ABILITATION	STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	IIP CODE:		
(X4) ID		OF DEFICIENCIES (EACH DE	FICIENCY	ID	DROVIDED'S DI AN OF CODDE	CTION (EACH	(X5)
PREFIX TAG	MUST BE PRECEEDE IDENTII	ED BY FULL REGULATORY OF		PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	COMPLETE DATE
F 0760	Continued from page 50			F 0760			
SS=E					6. All residents were revie ensure that they did not have duplicate orders for Synthroi Licensed staff educated on documenting throxine. Systematic Change: 1. Nurse involved educate rights to include process for medications are going to be left. 2. All nurses educated on to include timely administrat process for if medication is going be late by DON 3. Ad hoc Quality Assurar Performance Improvement in occurred on Monday (5/8) to findings. 4. Pharmacist reviewed medications to see medication at med times. 5. Nurse involved not to a medcart. 6. Licensed staff were edusliding scale insulin and coverage and thy 7. Licensed staff were edusliding insulin and coverage and thy 7. Licensed staff were edusliding scale insulin were eduslided.	ed on 6 if late 6 rights tion, going to nee neeting o review on load ssume a neated on erage g scale groxine.	

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 51 of 76

	OF DEFICIENCIES AND RRECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:			PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	EY
		395398			<u>vv</u>	05/18/2023	
SOMERSE CENTER	VIDER OR SUPPLIER: ET HEALTHCARE & REH SE NUMBER: 970202	ABILITATION	STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	IIP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF IDENTIFYING INFORMATION)		ED BY FULL REGULATORY OF		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0760 SS=E	Continued from page 51			F 0760	duplicate medications and discontinuing orders with stanew orders. Monitoring of the change to system compliance ongoing: 1. Monitor resident #17 ar medications 5 times a week to medications are timely for 4 2. Nurse manager to perform pass observation randomly on urses on variable shifts 2 times week for 4 weeks. 3. Nurse manager to monishiding scale insulin and block sugars and Synthroid for duporders five times a week for 4. Findings to be reviewed Quality Assurance Performa Improvement for review and recommendations by the Dir Nursing.	sustain and # 77 to ensure weeks. form med in mes a tor od blicate 4 weeks. d with ince	

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 52 of 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION: (X3) DATE SURV COMPLETED: A. BLDG: _00		ΞY		
		395398		B. WING: _		05/18/2023	
SOMERSE CENTER	VIDER OR SUPPLIER: T HEALTHCARE & REH E NUMBER: 970202	ABILITATION	STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	MP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEI PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0760 SS=E	Based on review of clin interviews, it was deter to ensure that it was freerrors for two of 38 res 17, 77). Findings include: An Annual Minimum I (a mandated assessmer care needs) for Resider revealed that the reside to understand others, redaily care needs, had diabetes (a disease that control), and received in Physician's orders for I 2021, included an order blood sugar before mean Physician's orders, date	Data Set (MDS) asset of a resident's abilit 17, dated April 6, and was understood a required extensive assiagnoses that include interferes with bloomsulin. Resident 17, dated Mar to check the residents and at bedtime.	essment ities and 2023, and able sist with ed d sugar	F 0760			
	order for the resident to	-					

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 53 of 76

· · · · · · · · · · · · · · · · · · ·		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
	395398			A. BLDG: _ B. WING: _	00	05/18/2023	
SOMERSE CENTER	VIDER OR SUPPLIER: ET HEALTHCARE & REH SE NUMBER: 970202	ABILITATION	STREET ADDRESS, 228 SIEMON I SOMERSET,	DRIVE	IIP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DI PREFIX MUST BE PRECEEDED BY FULL REGULATORY (TAG IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE	
F 0760	Continued from page 53	ontinued from page 53		F 0760			
SS=E	(fast acting) insulin if I milligrams per decilite units of Humalog insul between 251 mg/dl and Humalog insulin if her mg/dl and 350 mg/dl, her blood sugar is between 401 m A review of the Medic (MAR's) for Resident revealed that the reside 2023, at 4:30 p.m. was 2023, at 4:30 p.m. was 2023, at 4:30 p.m. was 2023, at 11:30 a.m. wa 2023, at 4:30 p.m. was 2023, at 11:30 a.m. wa 2023, at 11:30 a.m. was 2023, at 4:30 p.m. was	r (mg/dl) and 250 m lin if her blood sugar d 300 mg/dl, 9 units blood sugar is betw 12 units of Humalog yeen 351 mg/dl and 4 Humalog insulin if hand and 450 mg/dl ation Administration 17 for April and May ent's blood sugar on 211 mg/dl; on April 233 mg/dl; on April 233 mg/dl; on April s 300 mg/dl; on April s 205 mg/dl; on April 234 mg/dl; on April 234 mg/dl; on April 235 mg/dl; on April 236 mg/dl; on April 237 mg/dl; on April s 300 mg/dl; on April s 300 mg/dl; on April s 313 mg/dl; on April	g/dl, 6 r is of een 301 insulin if 400 ner blood . n Records y 2023 April 5, 16, 18, 19, 114, iil 18, iil 23, 124, 126, y 6,				

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 54 of 76

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		395398			<u>uv</u>	05/18/2023	
SOMERSE CENTER	VIDER OR SUPPLIER: CT HEALTHCARE & REH SE NUMBER: 970202	ABILITATION	STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	IIP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0760 SS=E	Continued from page 54 2023, at 11:30 p.m. wadocumented evidence of given for blood sugars these dates and times at Interview with the Nur May 18, 2023, at 12:11 scale Humalog insulin above-mentioned dates been. A quarterly MDS assest dated February 22, 202 was sometimes underst understand, and had din hypothyroidism (when make enough thyroid heads). A care plan for 21, 2023, revealed that hypothyroidism and staresident's thyroid mediendocrinologist (a doctor problems with horm	that the Humalog insigned greater than 200 mg is ordered by the physical p.m. confirmed that was not administered and time but should same the tood, could sometime agnoses that include the thyroid gland do normones to meet your the resident had aff was not to changications without constor that treats disease that the took or that treats disease that the thyroid gland do normones to meet your the resident, dated aff was not to changications without constor that treats disease that the third is the treats disease that the third is the treats disease that the treats disease that the third is the treats disease that the treats disease that the treats disease that the treats disease the treats disease that the treats disease the treats disease the treats disease the treats disease that the treats disease t	sulin was ty/dl on ysician. Atter on tt sliding ted on the d have 77, resident tes d toes not tur body's March e the sulting the	F 0760			

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 55 of 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:		
		395398			00	05/18/2023	
SOMERSE CENTER	VIDER OR SUPPLIER: T HEALTHCARE & REH E NUMBER: 970202	ABILITATION	STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	CIP CODE:		
(X4) ID PREFIX TAG	PREFIX MUST BE PRECEEDED BY FULL REGULATORY O			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE
F 0760	Continued from page 55	Continued from page 55		F 0760			
SS=E							
	A nursing note for Res	-	14,				
	2023, at 6:53 a.m. reve						
	Registered Nurse Pract						
	registered nurse with a authority to write order	•					
	facility and made awar	*					
	stimulating hormone (•				
	measures this hormone						
	order was received to a	•	1110,11				
	microgram (mcg) table		(a				
	medicine used to treat						
	(hypothyroidism)) ever	ry morning and staff	was to				
	discontinue the admini	stration of the 125 n	ncg tablet				
	of Levothyroxine every	y morning.					
	A nursing note for Res	ident 77, dated Apri	1 4,				
	2023, at 10:43 a.m. rev	realed that per the					
	endocrinologist the res						
	one 175 mcg tablet of l		•				
	and staff was to discon						
	150 mcg tablet of Levo	othyroxine every mo	rning.				

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 56 of 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:		
		395398			<u></u>	05/18/2023	
SOMERSE CENTER	VIDER OR SUPPLIER: T HEALTHCARE & REH E NUMBER: 970202	ABILITATION	STREET ADDRESS, 228 SIEMON I SOMERSET, I	DRIVE	IIP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH D PREFIX MUST BE PRECEEDED BY FULL REGULATORY (IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0760 SS=E	Continued from page 56 There was no document 77's clinical record that Levothyroxine was dis 2023. The medication adminity 77 for April 2023 reveathe 150 mcg and the 17 Levothyroxine togethe and 15, 2023. Interview with the Ass May 18, 2023, at 10:45 administered both the 18 doses of Levothyroxine dates. 28 Pa. Code 211.12(d)	istration records for aled that staff admin 75 mcg doses of r on April 5, 6, 8, 11 istant Director of Nu 5 a.m. confirmed that 150 mcg and the 175 et to Resident 77 on the confirmation of the 175 et to Resident 77 on the confirmation of the 175 et to Resident 77 on the confirmation of the 175 et to Resident 77 on the confirmation of the 175 et to Resident 77 on the confirmation of the 175 et to Resident 77 on the confirmation of the 175 et to Resident 77 on the confirmation of the 175 et to Resident 77 on the confirmation of the 175 et to Resident 77 on the confirmation of the 175 et to Resident 77 on the confirmation of the 175 et to Resident 77 on the confirmation of the 175 et to Resident 77 on the 175 et to Resident 77	Resident istered , 12, 13, arsing on t staff is mcg the above	F 0760			
F 0867				F 0867			
SS=D							

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 57 of 76

	OF DEFICIENCIES AND RRECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 395398		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:			(X3) DATE SURVEY COMPLETED: 05/18/2023	
SOMERSE CENTER	VIDER OR SUPPLIER: ET HEALTHCARE & REH	ABILITATION	STREET ADDRESS 228 SIEMON SOMERSET,	DRIVE	IP CODE:			
	SE NUMBER: 970202	OF DEFICIENCIES (FACH DE	PEIGIENGY	ID	PROVIDENCE N. AVIOR CORRE	OTTON (F. A CH	(V5)	
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0867	Continued from page 57			F 0867				
SS=D							Completion	
	483.75(c)(d)(e)(g)(2)(i)(ii) (Activities §483.75(c) Program feedback A facility must establish and procedures for feedback, da monitoring, including adver policies and procedures must following: §483.75(c)(1) Facility main obtain and use of feedback a other staff, residents, and re including how such informa problems that are high risk, and opportunities for improv §483.75(c)(2) Facility main identify, collect, and use dat departments, including but a ssessment required at §483 information will be used to performance indicators. §483.75(c)(3) Facility devel evaluation of performance i methodology and frequency monitoring, and evaluation. §483.75(c)(4) Facility advel	ck, data systems and mod implement written pol ta collections systems, a see event monitoring. The strinclude, at a minimum tenance of effective system input from direct casident representatives, attion will be used to identify the volume, or problem tenance of effective system and information from the timited to the facility of the	onitoring. icies and and ae n, the tems to re staff, ntify m-prone, tems to all y w such		A subcommittee of the Qual Assurance Performance Improvement Committee wi developed to review the folk tags (F 689, F 730, F 760, F 883) Each F tag mentioned vaudited to determine if there improvement. If improvement is not noted, subcommittee will utilize a ranalysis to determine what changed to prevent these recideficiencies. Performance Improvement F (PIPs) will be developed for tag mentioned before to diremonitor each F tag's improvement of the subcommittee (the Administrator/designee), most the Quality Assurance Performance Improvement for review and recommendations.	Il be owing F 880, and F will be is then the root cause ould be urring Plans each F ctly ement. by the ne onthly, to rmance	Completion Date: 06/09/2023 Status: APPROVED Date: 06/12/2023	

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 58 of 76

	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/CIDENTIFICATION NUMBER 395398		A. BLDG:	PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED: 05/18/2023	ΣY
SOMERSE CENTER	VIDER OR SUPPLIER: THEALTHCARE & REH SE NUMBER: 970202		STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	IP CODE:		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH D MUST BE PRECEEDED BY FULL REGULATORY (IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0867 SS=D	the methods by which the faidentify, report, track, invest information relating to adverse including how the facility wactivities to prevent adverse §483.75(d) Program system action. §483.75(d)(1) The facility in performance improvement a actions, measure its success ensure that improvements at \$483.75(d)(2) The facility in policies addressing: (i) How they will use a system action in How they will developed designed to effect change at quality of care, quality of lift (iii) How the facility will imperformance improvement a improvements are sustained §483.75(e) Program activities §483.75(e)(1) The facility in performance improvement a high-volume, or problem-prince improvement and high-volume, or problem-prince improve	tigate, analyze and use of the country of the count	data and //, op nic at those to d. eent rmine tems; fill be event nd of its	F 0867			

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 59 of 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBER:			C		(X3) DATE SURVEY COMPLETED:	
	395398				05/18/2023	
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	OF DEFICIENCIES (FACIL DE	EICIENCV	ID	DE COURTE DIG DE LA LA CE CORRE	CTION (F. I CH	(V5)
MUST BE PRECEEDE	D BY FULL REGULATORY O		PREFIX TAG	CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETE DATE
Continued from page 59			F 0867			
incidence, prevalence, and sareas; and affect health outcautonomy, resident choice, a §483.75(e)(2) Performance track medical errors and advitheir causes, and implement mechanisms that include feethe facility. §483.75(e)(3) As part of the activities, the facility must comprovement projects. The improvement projects condutthe scope and complexity of available resources, as reflect required at §483.70(e). Impat least annually a project the problem-prone areas identificant analysis described in pasection. §483.75(g) Quality assessm. §483.75(g)(2) The quality accommittee reports to the fact designated person(s) function regarding its activities, included.	omes, resident safety, reand quality of care. improvement activities are resident events, and preventive actions and edback and learning through the facility assessment and facility assess arovement projects must at focuses on high risk of ied through the data collar agraphs (c) and (d) of the ent and assurance. In the facility's governing body, only as a governing body, only as a governing body, only and implementation of the ent and assurance.	esident must alyze bughout ment ance of st reflect and sment include or lection this	F 0007			
this section. The committee	must:					
	VIDER OR SUPPLIER: T HEALTHCARE & REH ENUMBER: 970202 SUMMARY STATEMENT MUST BE PRECEEDE IDENTIFI Continued from page 59 incidence, prevalence, and s areas; and affect health outc autonomy, resident choice, a §483.75(e)(2) Performance track medical errors and adv their causes, and implement mechanisms that include fee the facility. §483.75(e)(3) As part of the activities, the facility must of improvement projects. The improvement projects conduthe scope and complexity of available resources, as reflect required at §483.70(e). Imp at least annually a project th problem-prone areas identifi and analysis described in patential and analysis described in patential section. §483.75(g) Quality assessm §483.75(g)(2) The quality accommittee reports to the fact designated person(s) function regarding its activities, include QAPI program required und	VIDER OR SUPPLIER: THEALTHCARE & REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION) Continued from page 59 incidence, prevalence, and severity of problems in t areas; and affect health outcomes, resident safety, re autonomy, resident choice, and quality of care. \$483.75(e)(2) Performance improvement activities track medical errors and adverse resident events, an their causes, and implement preventive actions and mechanisms that include feedback and learning three facility. \$483.75(e)(3) As part of their performance improve activities, the facility must conduct distinct perform improvement projects. The number and frequency comprovement projects conducted by the facility must the scope and complexity of the facility's services at available resources, as reflected in the facility asses required at \$483.70(e). Improvement projects must at least annually a project that focuses on high risk of problem-prone areas identified through the data coll and analysis described in paragraphs (c) and (d) of the section. \$483.75(g) Quality assessment and assurance. \$483.75(g) The quality assessment and assurance committee reports to the facility's governing body, of designated person(s) functioning as a governing bor regarding its activities, including implementation of	WIDER OR SUPPLIER: THEALTHCARE & REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 59 incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. \$483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. \$483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at \$483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. \$483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of	A BLDG: 395398 STREET ADDRESS, CITY, STATE, 2 228 SIEMON DRIVE SOMERSET, PA 15501 ENUMBER: 970202 ENUMBER: 970202 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 59 F 0867 Continued from page 59 F 0867 F 0867 F 0867 F 0867 F 0867 F 0867 A BLDG: B WING:	A BLDGoe_B_WING: 395398	DIDNITIES AND HANDER System Syste

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 60 of 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
	395398		B. WING:		05/18/2023	
NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHA CENTER STATE LICENSE NUMBER: 970202	STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	IP CODE:			
(X4) ID SUMMARY STATEMENT PREFIX MUST BE PRECEEDED TAG IDENTIF		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0867 Continued from page 60 SS=D (ii) Develop and implement correct identified quality def (iii) Regularly review and an collected under the QAPI prodrug regimen reviews, and a improvements. This REQUIREMENT is no	ficiencies; nalyze data, including da ogram and data resultin ct on available data to r	ata g from	F 0867			

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 61 of 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395398		A. BLDG: _ B. WING: _	00	05/18/2023	
SOMERSE CENTER	VIDER OR SUPPLIER: T HEALTHCARE & REH E NUMBER: 970202	ABILITATION	STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	CIP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0867	Continued from page 61			F 0867			
SS=D							
	Based on review of the						
	and the results of the co	• • • • • • • • • • • • • • • • • • • •					
	determined that the fac						
	Performance Improvento correct quality defic	` ` '					
	to improve the delivery		-				
	effectively addressed re						
	circuively addressed is	ecurring deficiencies	3.				
	Findings include:						
	The facility's deficiencies and plans of correction a State Survey and Certification (Department of Health) survey ending May 25, 2022, revealed that the facility developed plans of correction that included quality assurance systems to ensure that facility-maintained compliance with cited nursing home regulations. The results of the current surve ending May 18, 2023, identified repeated deficiencies regarding accident hazards, nurse aid performance reviews, significant medication error infection control, and influenza and pneumococca vaccines.						

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 62 of 76

		(XI) PROVIDER/SUPPLIER/OIDENTIFICATION NUMBER	I ' '		PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	EY
		395398				05/18/2023	
SOMERSE CENTER	VIDER OR SUPPLIER: IT HEALTHCARE & REH E NUMBER: 970202	ABILITATION	STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	MP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0867 SS=D	The facility's plan of correction for a deficiency regarding a failure to ensure that the resident environment remained free from accident hazards, cited during the survey ending May 25, 2022, revealed that the facility developed a plan that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F689,			F 0867			
	revealed that the QAPI committee failed to successfully implement their plan to ensure ongoing compliance with the regulations regarding accident hazards. The facility's plan of correction for a deficiency regarding a failure to ensure ongoing compliance with the regulations regarding nurse aide						
	performance reviews, of May 25, 2022, revealed plan that included come the results of the audits review. The results of under F730, revealed the	cited during the surved that the facility depleting audits and rest to the QAPI comments the current survey, or	veloped a eporting ittee for cited				

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 63 of 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/CU IDENTIFICATION NUMBER:					(X3) DATE SURVI COMPLETED:	C3) DATE SURVEY DMPLETED:	
		395398		B. WING:		05/18/2023	
SOMERSE CENTER	VIDER OR SUPPLIER: T HEALTHCARE & REH E NUMBER: 970202	ABILITATION	STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	MP CODE:		
(X4) ID		OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORREC	CTION (EACH	(X5)
PREFIX TAG	MUST BE PRECEEDE	ED BY FULL REGULATORY OF		PREFIX TAG	CORRECTIVE ACTION SHE	OULD BE	COMPLETE DATE
F 0867	Continued from page 63			F 0867			
SS=D	failed to successfully in ongoing compliance we nurse aide performance. The facility's plan of coregarding a failure to ewith the regulations regerrors, cited during the 2022, revealed that the included completing au of the audits to the QAThe results of the currerevealed that the QAPI successfully implement compliance with the remedication errors. The facility's plan of coregarding a failure to medication program, cited 25, 2022, revealed that	orrection for a defici- nsure ongoing comp garding significant in survey ending May facility developed a ditts and reporting the PI committee for revent survey, cited und committee failed to to their plan to ensure gulations regarding	ency cliance nedication 25, plan that ne results view. er F760 e ongoing significant ency infection nding May	F 0007			
	of correction that inclu reporting the results of						

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 64 of 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395398		A. BLDG: _ B. WING: _		05/18/2023	
SOMERSE CENTER	VIDER OR SUPPLIER: THEALTHCARE & REH SE NUMBER: 970202	IABILITATION	STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	MP CODE:		
(X4) ID PREFIX TAG	FIX MUST BE PRECEEDED BY FULL REGULATORY O			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE
F 0867	Continued from page 64			F 0867			
SS=D	committee for review. survey, cited under F8: QAPI committee failed their plans to ensure or regulations regarding in The facility's plan of coregarding a failure to ewith the regulations repneumococcal vaccine ending May 25, 2022, developed a plan that if and reporting the result committee for review. survey, cited under F8: committee failed to survey to ensure ongoing committee failed to survey and regarding influenza and Refer to F689, F730, F28 Pa. Code 201.14(a)	80, revealed that the d to successfully impaging compliance varietion control. orrection for a deficient ensure ongoing compagarding influenza and estables, cited during the surevealed that the factorical completing to the audits to the The results of the cressfully implement apliance with the registed pneumococcal vactorical vactorical ensured en	facility's olement with ency cliance describing audits a QAPI current QAPI their plan culations cines.				

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 65 of 76

PLAN OF CORRECTION (POC) IDENTIFICATION NUMB		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 05/18/2023	
NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHABILITATION			STREET ADDRESS, 228 SIEMON	CITY, STATE, Z DRIVE		U3/10/2U23	
CENTER			SOMERSET,	PA 15501			
	E NUMBER: 970202						
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0880				F 0880			
SS=D							

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 66 of 76

PLAN OF CORRECTION (POC) REAL OF CORRECTION (POC) DENTIFICATION NUMBER			· '		COMPLETED:		
		395398				05/18/2023	
	VIDER OR SUPPLIER: CT HEALTHCARE & REH	ABILITATION	STREET ADDRESS 228 SIEMON SOMERSET	DRIVE	IIP CODE:		
STATE LICENS	SE NUMBER: 970202						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE A	(X5) COMPLETE DATE	
F 0880	Continued from page 66			F 0880			
SS=D	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control						
	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control						Completion
	\$492.90 Infaction Control				Interventions for affected res	sident:	Date: 06/09/2023
	§483.80 Infection Control The facility must establish and maintain an infection				Dagidant #011a da ar immadia	atalı, had	00/09/2023 Status:
	prevention and control prog				Resident #81's door immedia a sign added advising staff to	-	APPROVED
	sanitary and comfortable en				a sign added advising starr to aware of Methicillin Resistar	Date:	
	the development and transm				Staphylococcus Aureus (MR		06/12/2023
	diseases and infections.	iission of communication	C		precautions. In addition, the		
	discuses and infections.				resident's catheter bag was re		
	§483.80(a) Infection preven	tion and control prograi	m.		from the floor and replaced.		
	The facility must establish a				1		
	control program (IPCP) that	-					
	following elements:	,	ŕ		Interventions for residents id	lentified	
					as having the potential to be		
	§483.80(a)(1) A system for	preventing, identifying,	,		affected:		
	reporting, investigating, and	l controlling infections a	and				
	communicable diseases for	all residents, staff, volu	nteers,		Residents with a Foley cathe		
	visitors, and other individua	-	nder a		reviewed with the nurses' aid		
	contractual arrangement bas	-			nurses to ensure they are nev	er on	
	assessment conducted accor				the floor and always placed		
	following accepted national	standards;			appropriately-that being abo	ve the	
					floor and below the bladder.		
	§483.80(a)(2) Written stand				To Condition and 1 C		
	for the program, which mus	•			Infections reviewed for appr	opriate	
	(i) A system of surveillance	designed to identify po	ssible		isolation precautions by the Interdisciplinary care plan te	am	
	communicable diseases or infections before they can sp	proad to other margare :	n tha		Nursing staff to be educated		
		preau to other persons if	n me		MRSA and the appropriate	OII	
	facility; (ii) When and to whom possible incidents of communicable		unicable		isolations precautions to be t	aken as	
	disease or infections should		unicavic		per CDC guidance.	micon us	
	and the control of th	oo reported,			r cz c Bardanee.		1

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 67 of 76

STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/CLL/PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED:	
	395398				05/18/2023	
NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHABILITATION CENTER STATE LICENSE NUMBER: 970202			DRIVE	IP CODE:		
MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATI		
Continued from page 67			F 0880			
(:::) Chan dand and harmonical		. L.				
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			reviewed to ensure bag is plata appropriately. Infections will be reviewed by interdisciplinary care plan to ensure appropriate Isolation precautions are implemented on Centers for Disease Control (C.D.C.) guidance. Monitoring of the change to system compliance ongoing: Foley bags will be checked by Director of Nursing (D.O.N.) designee to ensure they are not the floor 5 times a week for a then randomly for 2 months. Infections will be reviewed, D.O.N. or designee, 5 times ensure appropriate isolation precautions are implemented.	oy the am to I based rol sustain by the or not on 4 weeks by the a week to		
	VIDER OR SUPPLIER: T HEALTHCARE & REH ENUMBER: 970202 SUMMARY STATEMENT MUST BE PRECEEDE IDENTIFY Continued from page 67 (iii) Standard and transmissify followed to prevent spread (iv) When and how isolation including but not limited to: (A) The type and duration of the infectious agent or organ (B) A requirement that the irestrictive possible for the recircumstances. (v) The circumstances under prohibit employees with a confected skin lesions from done their food, if direct contact of (vi) The hand hygiene proceinvolved in direct resident contact of (vi) The hand hygiene proceinvolved in direct resident contact of (vi) The hand hygiene proceinvolved in direct resident contact of (vi) The hand hygiene proceinvolved in direct resident contact of (vi) The hand hygiene proceinvolved in direct resident contact of (vi) The hand hygiene proceinvolved in direct resident contact of (vi) The hand hygiene proceinvolved in direct resident contact of (vi) The hand hygiene proceinvolved in direct resident contact of (vi) The hand hygiene proceinvolved in direct resident contact of (vi) The hand hygiene proceinvolved in direct resident contact of (vi) The hand hygiene proceinvolved in direct resident contact of (vi) The hand hygiene proceinvolved in direct resident contact of (vi) The hand hygiene proceinvolved in direct resident contact of (vi) The hand hygiene proceinvolved in direct resident contact of (vi) The hand hygiene proceinvolved in direct resident contact of the hygiene proceinvolved in direct contact of the hygiene proceinvolved in direct resident contact of the hygiene proceinvolved in direct contact of the hygiene proceinvolved in direct resident contact of the hygiene procei	VIDER OR SUPPLIER: T HEALTHCARE & REHABILITATION E NUMBER: 970202 SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY OF IDENTIFYING INFORMATION) Continued from page 67 (iii) Standard and transmission-based precautions to followed to prevent spread of infections; (iv) When and how isolation should be used for a resincluding but not limited to: (A) The type and duration of the isolation, depending the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease on infected skin lesions from direct contact with reside their food, if direct contact will transmit the disease (vi)The hand hygiene procedures to be followed by involved in direct resident contact. §483.80(a)(4) A system for recording incidents ider under the facility's IPCP and the corrective actions the facility. §483.80(e) Linens. Personnel must handle, store, process, and transports on as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPC	WIDER OR SUPPLIER: THEALTHCARE & REHABILITATION SOMERSET, ENUMBER: 970202 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 67 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	A BLDG: 395398 STREET ADDRESS, CITY, STATE, Z 228 SIEMON DRIVE SOMERSET, PA 15501 ENUMBER: 970202 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 67 F 0880 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(c) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	A BLDG:	IDENTIFICATION NUMBER 395398 STREET ADDRESS. CITY. STATE, ZIP CODE 28 SIEMON DRIVE SOMERSET, PA 15501 STREET ADDRESS. CITY. STATE, ZIP CODE 28 SIEMON DRIVE SOMERSET, PA 15501 STREET ADDRESS. CITY. STATE, ZIP CODE 28 SIEMON DRIVE SOMERSET, PA 15501 STREET ADDRESS. CITY. STATE, ZIP CODE 28 SIEMON DRIVE SOMERSET, PA 15501 STREET ADDRESS. CITY. STATE, ZIP CODE 28 SIEMON DRIVE SOMERSET, PA 15501 STREET ADDRESS. CITY. STATE, ZIP CODE 28 SIEMON DRIVE SOMERSET, PA 15501 F 0880 Systematic Change: (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. \$483.80(a)(4) A system for recording incidents identified under the facility. \$483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. \$483.80(b) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. \$483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 68 of 76

	STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395398		B. WING: _		05/18/2023	
	VIDER OR SUPPLIER: IT HEALTHCARE & REH	ABILITATION	STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	IP CODE:		
STATE LICENS	E NUMBER: 970202						
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F 0880	Continued from page 68			F 0880			
SS=D							

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 69 of 76

STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER:			COMPLETED:		(X3) DATE SURVI COMPLETED:	EY	
		395398		A. BLDG: _ B. WING: _	00	05/18/2023	
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F 0880	Continued from page 69			F 0880			
SS=D							
	Based on review of gui	idance from the Cen	ters for				
	Disease Control (CDC-	-the national health					
	protection agency) and	clinical record revie	ew, as				
	well as observations an	nd staff interviews, it	t was				
	determined that the fac	ility failed to follow	proper				
	infection control polici	es related to urinary	catheter				
	care and failed to follow		o reduce				
	the spread of infections	-					
	cross-contamination re						
	Staphylococcus Aureus						
	multidrug-resistant org residents reviewed (Re		one of 38				
	Findings include:						
	CDC guidance on isola	ation precautions for	MRSA				
	residents contained in l						
	Protective Equipment ((PPE) Use in Nursin	g Homes				
	to Prevent Spread of M	` '	•				
	(MDROs), dated July 1	12, 2022, indicates tl	hat				
	multidrug-resistant org	anism (MDRO) tran	nsmission				
	is common in skilled n	ursing facilities, con	tributing to				

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 70 of 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBER:			(X2) MULTI	PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	EΥ
` '	395398				05/18/2023	
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increased healthcare corprecautions (EBP) are intervention designed to resistant organisms that glove use during high of EBP may be indicated do not otherwise apply following: Wounds or regardless of MDRO confection or colonization. A quarterly Minimum (a mandated assessment care needs) for Resider revealed that the reside understood and could strequired extensive assistant inserted into the bladded.	an infection control or reduce transmission to the property of the	on of gown and activities. autions any of the devices, ad/or essment ities and , 2023, ad others, ds, had an that is d had	F 0880			
	VIDER OR SUPPLIER: T HEALTHCARE & REH ENUMBER: 970202 SUMMARY STATEMENT MUST BE PRECEEDED IDENTIFY Continued from page 70 substantial resident modern increased healthcare concentrated by the indicated do not otherwise apply following: Wounds or regardless of MDRO confection or colonization. A quarterly Minimum (a mandated assessment care needs) for Resident revealed that the resident understood and could stated the included diagnoses that included	SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION) Continued from page 70 substantial resident morbidity and mortality increased healthcare costs. Enhanced Barr Precautions (EBP) are an infection control intervention designed to reduce transmission resistant organisms that employs targeted gove use during high contact resident care EBP may be indicated (when Contact Precado not otherwise apply) for residents with a following: Wounds or indwelling medical regardless of MDRO colonization status are infection or colonization with an MDRO. A quarterly Minimum Data Set (MDS) asse (a mandated assessment of a resident's abilicare needs) for Resident 81, dated April 12 revealed that the resident was sometimes understant required extensive assist for daily care needs indwelling urinary catheter (a flexible tube inserted into the bladder to drain urine), and diagnoses that included neurogenic bladder.	VIDER OR SUPPLIER: THEALTHCARE & REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 70 substantial resident morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status and/or infection or colonization with an MDRO. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 81, dated April 12, 2023, revealed that the resident was sometimes understood and could sometimes understand others, required extensive assist for daily care needs, had an indwelling urinary catheter (a flexible tube that is inserted into the bladder to drain urine), and had diagnoses that included neurogenic bladder (lack of	A BLDG: 395398 STREET ADDRESS, CITY, STATE, 228 SIEMON DRIVE SOMERSET, PA 15501 ENUMBER: 970202 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 70 F 0880 Continued from page 70 F 0880 Continued from page 70 F 0880 F 0880 A BLDG: 228 SIEMON DRIVE SOMERSET, PA 15501 F 0880 F 0880 F 0880 A BLDG: 228 SIEMON DRIVE SOMERSET, PA 15501 F 0880 F 0880 F 0880 A BLDG: 228 SIEMON DRIVE SOMERSET, PA 15501 F 0880 F 0880 A GRAND OF THE SOMERSET OF THE SOME SOMERSET OF THE SOMERSET OF THE SOME SOMERSET OF THE SOME SOME SOME SOME SOME SOME SOME SOM	A BLDG: 00 B WING:	A BLDG: 90 B WING: COMPLETED 395398 STREET ADDRESS CITY, STATE, JIP CODE: 228 SIEMON DRIVE SOMERSET, PA 15501 SUMMARY STATEMENT OF DEFICIENCES (BACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCES (BACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOOTIGINATION OF THE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE Continued from page 70 Substantial resident morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status and/or infection or colonization with an MDRO. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 81, dated April 12, 2023, revealed that the resident was sometimes understood and could sometimes understand others, required extensive assist for daily care needs, had an indwelling urinary catheter (a flexible tube that is inserted into the bladder to drain urine), and had diagnoses that included neurogenic bladder (lack of

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 71 of 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION: (X3) DATE SUI COMPLETED: A. BLDG:00_		(X3) DATE SURVI COMPLETED:	EΥ	
		395398		B. WING: _	<u></u>	05/18/2023	
SOMERSE CENTER	VIDER OR SUPPLIER: T HEALTHCARE & REH	ABILITATION	STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	MP CODE:		
1	E NUMBER: 970202	OF DEFICIENCIES (FACH DE	FIGUENOV	ID			(7/5)
PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0880	Continued from page 71			F 0880			
SS=D	Physician's orders for Resident 81, dated May 12,						
	2023, included an orde		-				
	100 milligrams (mg) of	f Minocycline (an ar	ntibiotic)				
	two times a day for ten	days for MRSA in	the left				
	hip wound.						
	Observations on May 1	15, 2023, at 11:30 a.:	m. of				
	Resident 81's room rev						
	containing personal pro	otective equipment (PPE)				
	beside the room entran	ce. An interview wi	ith				
	Licensed Practical Nur	se 7 at that time idea	ntified				
	Resident 81 as having	MRSA in a wound a	ınd				
	confirmed that there w	as no sign on the res	sident's				
	door advising staff and	visitors of the need	for				
	precaution. An intervi						
	Nursing at this time co						
	in isolation for MRSA,		e a sign on				
	the door advising preca	autions					
	Observations of Reside	ent 81 on May 18, 20	023, at				
	10:29 a.m. revealed that	at the resident was ly	ing in				
	bed with his urinary ca						
	An interview with Reg	istered Nurse 7 at th	at time				

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 72 of 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
395398				00	05/18/2023		
NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHABILITATION CENTER STATE LICENSE NUMBER: 970202			STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	MP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFI PREFIX MUST BE PRECEEDED BY FULL REGULATORY OR TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0880 SS=D	confirmed that the resident's catheter bag was lying on the floor and should not have been. Interview with the Infection Control Nurse on May 18, 2023, at 10:48 p.m. revealed that Resident 81 was being treated for a MRSA infection in his left hip wound, and that only standard precautions were required because his wound was contained in a clean dressing. She further revealed that the facility's policy is to use standard precautions for the care and treatment of an active MRSA infection and that contact precautions (including the use of gloves and gowns) were not required for any care, including care of a MRSA infected wound. An interview with the Director of Nursing on May		F 0880				
	18, 2023, at 2:52 p.m. revealed that his understanding of CDC recommendations is that contact isolation is not required for MRSA positive wounds if the wound is contained; therefore, contact isolation was not used. 28 Pa. Code 201.14(a) Responsibility of licensee.						

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 73 of 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
395398						05/18/2023	
NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHABILITATION CENTER STATE LICENSE NUMBER: 970202			STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	IP CODE:		
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F 0880	Continued from page 73			F 0880			
SS=D							
	28 Pa. Code 201.18(b)	(1)(3)(d)(e)(1)					
	Management.						
	28 Pa. Code 211.10(d)	Resident care polici	ies.				
F 0883				F 0883			
SS=D							

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 74 of 76

PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIEM (XI) PROVIDER/SUPPLIEM (DENTIFICATION NUMBER					COMPLETED:		
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NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	IP CODE:		
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F 0883	Continued from page 74			F 0883			
SS=D							
	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;		ions policies n resident ne ion sident t; the tation s titial unization nust , each ccation		Resident #8 will be offered influenza vaccine next season. Family and physician notified of omitted vaccine. Residents were reviewed to ensure that they had received the influenza vaccine if consented. Infection preventionist was educated on administering influenza vaccine when resident is admitted in influenza season by the Vice President of Clinical Services. Infection preventionist was educated on administering influenza vaccine when resident is admitted in influenza season by the Vice President of Clinical Services. The infection preventionist was also educated on keeping a roster of active residents with consents for the vaccine and vaccine administration. Residents will be reviewed on admission and annually to ensure		Completion Date: 06/09/2023 Status: APPROVED Date: 06/12/2023

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 75 of 76

PLAN OF CORRECTION (POC) IDEN		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 395398	₹:		PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 05/18/2023	
NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHABILITATION CENTER STATE LICENSE NUMBER: 970202			STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	IIP CODE:		
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F 0883 SS=D	F 0883 Continued from page 75		the tation s stial	F 0883	appropriate consent is obtain vaccine is administered by the infection preventionist. Infection Preventionist will renew admissions to ensure into consents are signed and residual placed on list for next influence season weekly for 4 weeks the monthly for 2 months.	nonitor Fluenza Hent nza	

CMS-2567L 78GN11 IF CONTINUATION SHEET Page 76 of 76

Pennsylvania Department of Health

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:		
		395398	B. WING:			05/18/2023		
SOMERSET HEALTHCARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE: 228 SIEMON DRIVE SOMERSET, PA 15501					
	E NUMBER: 970202							
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P 0555				P 0555				
I ADOD (MONY)	DIRECTORIS OF BLOCKERS (A. 1997)	ED DEDDECENTAL STATES CASCA	ATURE		THE P			
LABUKATUKY	DIRECTOR'S OR PROVIDER/SUPPLI	ER REPRESENTATIVE'S SIGN	ATUKE		TITLE:	(X6) DATE:		

State Form 78GN11 IF CONTINUATION SHEET Page 1 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00_		(X3) DATE SURVEY COMPLETED:	
		395398				05/18/2023	
NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHABILITATION CENTER STATE LICENSE NUMBER: 970202			STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	IIP CODE:		
				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
P 0555	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC		P 0555	Licensed Practical Nurse #8 their annual training for fire prevention and safety, disast preparedness, and restorative nursing techniques on 6/8/23 Director of Nursing (D.O.N. Maintenance Director. All employees were reviewe Human Resources Director of to ensure that appropriate tra was obtained for License Pra Nurse #8 as well as other sta All employees were trained b D.O.N. and Maintenance Dir 6/8/23 for restorative nursing techniques, disaster prepared and fire prevention and safet The Human Resources Direct keep a roster of all employee audits of each employee's fil ensure staff receive appropri in-servicing. This will be co by the Human Resources Dir for 2 months. Findings will be reported by	ser e e e e e e e e e e e e e e e e e e	Completion Date: 06/09/2023 Status: APPROVED Date: 06/12/2023	

State Form 78GN11 IF CONTINUATION SHEET Page 2 of 4

Pennsylvania Department of Health

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:		
		395398		B. WING: _		05/18/2023		
NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE: 228 SIEMON DRIVE SOMERSET, PA 15501					
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P 0555	Continued from page 2			P 0555				
					Human Resources Director to Quality Assurance Performal Improvement committee for and recommendations.	nce		

State Form 78GN11 IF CONTINUATION SHEET Page 3 of 4

Pennsylvania Department of Health

PLAN OF CORRECTION (POC) IDENTIFY		(XI) PROVIDER/SUPPLIER/CIDENTIFICATION NUMBER	R: A. BLDG: _		IPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 05/18/2023		
NAME OF PROVIDER OR SUPPLIER: SOMERSET HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, 228 SIEMON SOMERSET,	DRIVE	ZIP CODE:			
STATE LICENS	E NUMBER: 970202							
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P 0555	Continued from page 3			P 0555				
	Based on a review of employee education records, as well as staff interviews, it was determined that the facility failed to ensure that employees completed the required education for one of eight employee files reviewed (Licensed Practical Nurse 8). Findings include: Review of the education record for Licensed Practical Nurse 8 revealed that she was hired by the facility on April 30, 2015. However, there was no documented evidence of annual training for fire prevention and safety, disaster preparedness, and restorative nursing techniques. Interview with the Director of Human Services on May 18, 2023, at 12:22 p.m. confirmed that there was no documented evidence that the above education was completed annually by Licensed Practical Nurse 8.		ed that the impleted bloyee b. ed ed by the was no r fire is, and in there is					

State Form 78GN11 IF CONTINUATION SHEET Page 4 of 4



Certified End Page

SOMERSET HEALTHCARE & REHABILITATION CENTER

STATE LICENSE NUMBER: 970202 SURVEY EXIT DATE: 05/18/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi

Deputy Secretary for Quality Assurance

fearre Janie

Debra L. Bogu MD

Debra L. Bogen, MD, FAAP Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY